

**BYLAWS AND  
RULES & REGULATIONS  
OF THE MEDICAL STAFF  
OF**

**WESTERLY HOSPITAL**

June 1, 2023

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## **PREAMBLE**

The Westerly Hospital, (hereinafter referred to as “the Hospital”) is a non-profit community hospital organized under the laws of the State of Rhode Island the purpose of which is to serve as a general hospital providing patient care and education. The Medical Staff is responsible for the quality of medical care in the Hospital and that cooperative efforts of the Medical Staff, the President/CEO and the Board are necessary to fulfill the Hospital’s obligations to its patients.

The physicians, dentists, podiatrists and Affiliated Health Care Professionals practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

## **DEFINITIONS**

“**Active Staff**” is defined to include Practitioners who have been assigned to the categories of “Active Attending” and “Active Referring”.

“**Board**” means the Board of Trustees of the Hospital, also referred to as "The Board," or, by The Joint Commission (TJC), as the “Governing Body”.

“**Bylaws**” means these Bylaws of the Medical Staff and, when used as a generic description, also shall include the Rules and Regulations of the Medical Staff, and Medical Staff Policies.

“**Chief Executive Officer**” means the individual appointed as the President in accordance with the Hospital’s corporate Bylaws to act on its behalf in the overall administrative management of the Hospital.

“**Clinical Privileges**” or “**privileges**” means the permission granted to an individual to render specific diagnostic, therapeutic, medical, or surgical services.

“**CMO**” means the Chief Medical Officer appointed by the Chief Executive Officer to act on its behalf in Medical Staff affairs in cooperation with the President of the Medical Staff. The Chief Medical Officer must meet requirements and be successfully appointed as a member of the Active Medical Staff.

“**Ex-officio**” means service as a member of a body by virtue of an office or position and, unless otherwise expressly provided, means without voting rights.

“**Affiliated Health Care Professionals**” (or “AHCP”) means, and is limited to: Physician Assistants, Certified Registered Nurse Anesthetists, Advanced Practice Registered Nurses and Clinical Psychologists. These AHCPs shall be individuals other than licensed physicians, dentists, and podiatrists whose patient care activities require supervision or collaboration by a physician member of the Medical Staff to whom they are assigned.

“**Hospital-based physician**” means a member of the Medical Staff who is in any one of the following Departments: Anesthesiology, Pathology/Clinical Laboratory, Emergency Medicine, Hospitalist Medicine, Radiology.

“**Hospitalist Group**” means the group of physicians under contract with the Hospital to provide inpatient coverage and management of patients within the Department of Medicine.

“**Medical Executive Committee**” (**MEC**) means the Medical Executive Committee of the Medical Staff.

“**Medical Staff**” means the formal organization of all physicians, dentists, and podiatrists who have been approved for membership and/or privileges in accordance with the terms outlined in these Bylaws.

**"Medical Staff Year"** For purposes of the business of the Medical Staff, the business year commences on the first day of October of each year and ends on the last day of September of the next year.

**"Member"** collectively refers to a "Member" of the Medical or Affiliated Health Care Professional Staff.

**"Ongoing Professional Practice Evaluation" (OPPE)** means the professional practice evaluation of Members and Affiliated Health Care Professional Members of the Medical Staff, and may include chart review, monitoring clinical practice pattern, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of patients (e.g., consulting physicians, assistants at surgery, nursing or administration personnel.)

**"Patient Contact"** means any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital.

**"Practitioner"** means an appropriately licensed medical physician, dentist, or podiatrist with a medical staff appointment.

**"Professional Liability Insurance" or "Malpractice Insurance"** means a policy of insurance, issued by a carrier licensed or authorized to do business in Connecticut or Rhode Island, as applicable or an appropriate program of self-insurance authorized to provide coverage in Connecticut or Rhode Island, as applicable, which meets the coverage limits and other terms specified by the Medical Executive Committee from time to time.

**"Yale New Haven Health System Affiliated Hospital"** shall include Yale New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital and any other hospital that affiliates with Yale New Haven Health.

## **INTEPRETATION**

Whenever the Bylaws do not specifically address a topic or cover a matter, or there is a need for interpretation, the MEC may issue an interpretation. In arriving at an interpretation, the MEC may take into account the usual and customary policies and practices of the Medical Staff, whether written or unwritten, and in its discretion may also bring to bear the expert medical knowledge of its members. MEC interpretations shall be maintained with the minutes of the MEC.

In the event that any law or regulation or mandatory Joint Commission or other applicable mandatory accreditation requirement clearly requires the Hospital or the Medical Staff to take particular action in connection with credentialing or any other matter covered by these Bylaws, such law, regulation, or accreditation requirement, unless specifically provided otherwise in the Bylaws, shall be complied with pending review by the Bylaws Committee, and to the extent possible, shall be construed as being consistent with the provisions of these Bylaws.

Once the Medical Staff becomes aware of the law, regulation, or requirement, the Bylaws Committee shall meet as soon as practical to review the law, regulation, or requirement at issue, seek input from legal counsel or other appropriate individual as the Bylaws Committee sees fit, and consider whether or not a revision to the Bylaws, based upon the law, regulation, or requirement is appropriate. If the Committee determines that an amendment to the Bylaws is appropriate, the Committee shall consider the appropriate amendment following the procedures set forth herein.

These Bylaws are not intended to create rights in any third parties; there are no third-party beneficiaries to these Bylaws.

**NON-DISCRIMINATION**

In accordance with Hospital and Medical Staff policy, all provisions of the Bylaws shall be interpreted and applied so that no person, Member, applicant, Hospital employee, patient, or any other person to whom reference is made directly or indirectly shall be subject to unlawful discrimination under any program or activity of the Hospital and its Medical Staff.

No aspect of Medical Staff appointment or granting of particular clinical privileges shall be denied to an individual on the basis of: age; sex; race; creed; color; national origin; a handicap unrelated to the ability to fulfill patient care and required staff obligations; or, any other criterion unrelated to the delivery of quality patient care in the hospital, to professional qualifications, to the hospital's purposes, needs and capabilities, or to community need.

Any reference to males or females, or use of the masculine or feminine gender in these Bylaws shall be interpreted as including both sexes.

**NATIONAL PRACTITIONER DATABANK AND RHODE ISLAND DEPARTMENT OF PUBLIC HEALTH REPORTING REQUIREMENTS**

The Chief Medical Officer shall comply with the requirements of the Health Care Quality Improvement Act of 1986 and the Regulations of the Department of Health and Human Services implementing the Act. In order to fulfill these requirements, the Chief Medical Officer will report, or cause to be reported, adverse actions when required and will obtain necessary information from the National Practitioner Data Bank (NPDB) in accordance with the law. The provisions of the Act and the Regulations, as they may be amended from time to time, hereby are incorporated into the Bylaws by this reference and to the extent possible shall be construed as being consistent with the provisions of these Bylaws and the Rules and Regulations.



## **ARTICLE I: NAME**

The name of this organization shall be "The Medical Staff of Westerly Hospital".

## **ARTICLE II: PURPOSES AND RESPONSIBILITIES**

The purposes of the medical staff as it relates to the Board are outlined as follows:

1. To provide a mechanism for accountability to the Board, through defined organizational components and positions, for the appropriateness of the patient care services, professional and ethical conduct of each individual appointed to the Medical Staff and each individual who, though not appointed to the Medical Staff, have been granted privileges.
2. To serve as the peer review body through which individual applicants and Members may obtain rights and clinical privileges at the Hospital, through which they fulfill the obligations of staff appointment.
3. To provide, on behalf of the Hospital, an appropriate educational setting for continuing medical education programs for Members of the medical staff.
4. To provide an orderly and systematic means by which Practitioners can give input to the Board of Trustees, Chief Medical Officer and Chief Executive Officer on medico-administrative problems and on the Hospital's policy-making and planning processes.

To effectuate the purposes outlined above, the responsibilities of the Medical Staff are further outlined as follows:

1. To participate in the Hospital's quality review and utilization management program by conducting all required and necessary activities for assessing, maintaining and improving the quality of medical care provided in the Hospital, including, but not limited to:
  - a. Evaluating Member and institutional performance through valid and reliable measurement systems based, when appropriate, on objective, clinically sound criteria;
  - b. Engaging in the ongoing monitoring of the provision of patient care;
  - c. Evaluating applicant eligibility and Member's credentials for appointment and reappointment to the Medical Staff and for the delineation of appropriate clinical privileges commensurate with licensure, education, training and experience which may be exercised by each individual Member; and
  - d. Promoting the appropriate use of the medical and health care resources of the Hospital for meeting the medical, social and emotional needs of patients.
2. To make recommendations through the MEC to the Board concerning appointments and reappointments including category and department assignments, clinical privileges, and, as necessary, corrective action.
3. To conduct and monitor medical education programs.
4. To develop and maintain these Bylaws, Rules and Regulations and medical staff policies in a manner that is consistent with sound professional practices, organizational principles, and external requirements, and to enforce compliance.

5. To participate in Hospital long range planning activities, to assist in identifying community health needs and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.
6. To exercise, through its Officers, committees and other defined components, the authority granted by these Bylaws to fulfill these responsibilities in a timely and proper manner and to account thereon to the Board.

### **ARTICLE III. MEDICAL STAFF MEMBERSHIP**

#### **SECTION 1      GENERAL STATEMENTS REGARDING MEDICAL STAFF MEMBERSHIP**

##### **1.1      Membership as a Privilege**

Membership on the Medical Staff of Westerly Hospital is a privilege that shall be extended only to professionally competent physicians, dentists, podiatrists and Health Professional Affiliates who continuously meet the eligibility requirements, qualifications and standards set forth in these Bylaws.

Appointment to and membership on the Medical or Affiliated Health Care Professional Staff shall confer only such clinical privileges as have been granted by the Board in accordance with these Bylaws.

##### **1.2      No Automatic Right to Membership**

No physician, dentist, podiatrist or Affiliated Health Care Professional shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual is duly licensed to practice in Rhode Island or any other state, or that the individual is a member of any professional organization, or because such individual is a member of a medical school faculty, or certified by any particular board, or that the individual had in the past, or presently has such privileges at another health care facility or in another practice setting.

##### **1.3      Facility/Resource Limitations**

The MEC or the Board may determine that the application and credentialing process cannot be completed, in whole or in part, based upon limitations in terms of the availability of Hospital resources or limitations of the facility itself. This determination may be based upon either:

- a. The Hospital's present inability as supported by documented evidence satisfactory to the Board or to the MEC to provide adequate facilities or support services for additional Practitioners and his/her patients in a certain specialty, or
- b. The Hospital's written plan of development or plan of patient care, including the types of patient care services to be provided or currently implemented.

Any such decision based on the above shall not be deemed adverse to any Practitioner, shall not be considered a denial of privileges or membership, and shall not entitle any Practitioner to the rights and provisions of the Fair Hearing Plan (ARTICLE XVIII or ARTICLE V, Section 6 as applicable).

#### **SECTION 2      ELIGIBILITY REQUIREMENTS**

Individuals who satisfy the requirements outlined below will be considered eligible for appointment or reappointment to the Medical Staff and clinical privileges, as applicable. These requirements apply during and after the time of any appointment, reappointment, or granting of clinical privileges.

2.1 Bylaws, Rules, Regulations and Policies

Applicants and current Medical Staff must agree to abide by Medical Staff Bylaws, Rules and Regulations, Hospital and Medical Staff Policies and Procedures

2.2 Identity Verification

At the time of initial application, all applicants must provide identity verification in the form of a notarized U.S. passport or driver's license in accordance with Medical Staff Administration policy;

2.3 Licensure

In order to be eligible for appointment, Medical Staff and Affiliated Medical Staff in all categories are required to have and maintain appropriate current licensure in the State of Rhode Island in their profession as outlined herein.

Applicants for Initial Appointment

Applicants for initial appointment must hold a current, unrestricted license to practice in the State of Rhode Island. Individuals whose State of Rhode Island license or license in any other State or country is currently restricted for any reason are not eligible. Restriction includes, but is not limited to probation, practice monitoring/oversight or a requirement for completion of additional training or education.

Applicants who have ever had a license in any state or country permanently revoked for any reason are not eligible for appointment.

Applicants with a history of a licensure action(s) in any state which have been resolved with no residual restrictions may be eligible for appointment. Consideration shall be given as to the concerns that gave rise to the licensure action, assessment of impact on privileges requested, time that has elapsed since resolution of the matter and patient safety. Such applicants are not eligible for temporary privileges.

Absent any other concerns regarding eligibility, applicants who are subject to a civil penalty, reprimand or censure with requirements limited solely to payment of a monetary fine or submission of administrative fees may be considered for appointment once verification has been obtained directly from the relevant state licensing board confirming that all obligations have been fulfilled with no residual licensure restrictions. Such applicants are not eligible for temporary privileges.

No hearing rights shall be afforded for failure to meet eligibility requirements related to licensure

Current Members

Consistent with ARTICLE VIII, Section 2 (Notification Requirement) Members of the Medical or Affiliated Health Care Professional Staff are required to notify the Chief Medical Officer and Medical Staff Administration immediately upon the occurrence of licensure action of any kind in the State of Rhode Island or any other state or country. This includes, but is not limited to, revocation, suspension, surrender, voluntary agreement not to exercise as well as entrance into a consent order for any purpose including, but not limited to, fine, censure, reprimand, probation, or restriction.

ARTICLE VIII, Section 3a outlines the consequences of various licensure actions.

2.4 Federal and State Drug Control Registration

When required in order to exercise clinical privileges, Medical Staff members must have and maintain a current, unrestricted, DEA registration in the State of Rhode Island as well as a State of Rhode Island Controlled Substance Certificate at all times.

Individuals applying for initial appointment may have a pending certificate or certificates. If either or both is pending, the applicant must complete the appropriate Federal DEA/State Controlled Substance Certificate Waiver Form in which they agree not to prescribe controlled substances at the Hospital until appropriate prescribing authority has been granted.

Applicants for initial appointment shall immediately become ineligible for appointment and clinical privileges if either or both Federal or State certificate are not able to be obtained or, once obtained, is restricted and no hearing rights shall be afforded.

Medical Staff members who do not renew their DEA certificates before expiration shall be required to complete a Federal DEA/State Controlled Substance Certificate Waiver Form in which they agree not to prescribe controlled substances at the Hospital until such certificate has been renewed.

ARTICLE VIII, Section outlines the consequences of actions taken against a Medical Staff member's Federal or State authority to prescribe controlled substances.

## 2.5 Education

### Physicians:

Physicians must be graduates of an allopathic or osteopathic medical school accredited for the duration of their attendance by the Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association, the American Osteopathic Association its successor agency.

Certification by the Education Commission for Foreign Medical Graduates (ECFMG) or evidence of having successfully completed a "Fifth Pathway" are acceptable alternative means of fulfilling this requirement.

### Dentists:

Dentists must be graduates of a dental school accredited for the duration of their attendance by Commission on Dental Accreditation of the American Dental Association or its successor agency.

### Podiatrists:

Podiatrists must be graduates of a podiatric school accredited for the duration of their attendance by the Council on Podiatric Medical Education of the American Podiatric Medical Association its successor agency.

The requirement for satisfactory completion of approved postgraduate training shall be waived for any Practitioner who was a member of the staff prior to the effective date of these Bylaws.

### CRNAs:

Certified Registered Nurse Anesthetists must be graduates of a state approved basic nursing education program and graduates of an education program accredited by the American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Education Programs.

### Nurse Practitioners:

Nurse Practitioners must be graduates of a state approved basic nursing education program, and graduates of a Board of Nurse Registration and Nursing Education approved course of study for nurse

practitioners conducted within an accredited academic institution. The course of study for nurse practitioners must include both a didactic component as well as supervised clinical experience.

Physician Assistants:

Physician Assistants must be graduates of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistants which is recognized by the Council for Higher Education Accreditation.

Other Affiliated Health Care Professionals:

Must be graduates of appropriately accredited educational programs relevant to their practice area.

2.6 Training

Physicians must have evidence of having successfully completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post graduate training program.

Dentists and Oral & Maxillofacial Surgeons, except for those engaged in the practice of general dentistry, must have evidence of having successfully completed at least one year of a residency program accredited by the Commission on Dental Accreditation (CODA).

Podiatrists must have evidence of having successfully completed a residency program accredited by the Council on Podiatric Medical Education.

An “accredited” postgraduate training program is one which is fully accredited, as applicable, throughout the time of the applicant's training by:

- the Accreditation Council for Graduate Medical Education; or
- the American Osteopathic Association; or
- the Commission on Dental Accreditation; or
- the Council on Podiatric Medical Education; or
- a successor agency to any of the foregoing

2.7 Competence

Applicants for Initial Appointment

In order to be eligible for appointment and privileges, applicants for initial appointment must provide, or cause to be provided, evidence of current professional competency to exercise the clinical privileges requested with reasonable skill and safety and sufficient to demonstrate to the Medical Staff and Board of Trustees that any patient treated will receive high quality medical care.

In order to be eligible for appointment and privileges, applicants for initial appointment may not have any of the following:

- a) a history of adverse professional review actions regarding medical staff membership or clinical privileges for reasons related to clinical competence or professional conduct including, but not limited to, denial, revocation or suspension (excluding precautionary suspension) of membership or clinical privileges; or

- b) any formal investigations or for cause Focused Professional Practice Evaluation (FPPE) pending resolution or completion at another institution; or
- c) previously resigned appointment or relinquished clinical privileges during a Medical Staff investigation or in exchange for not conducting such an investigation

Initial applicants with any of the above are not eligible for appointment. If such information is identified and verified during the application process, the applicant shall be notified accordingly and the application considered voluntarily withdrawn.

#### Current Members

Upon reappointment, current members of the Medical Staff must provide, or cause to be provided, evidence of the following:

- a) Have admitted or cared for a sufficient number of patients in the Hospital inpatient and/or outpatient settings to allow evaluation of continuing competence by the Chief of the relevant Department. This requirement is considered not applicable for individuals seeking appointment to the Active Referring or Referring Affiliated Health Care Professionals categories.
- b) Absent a sufficient volume of patient care activity at the Hospital, verification of competence and activity from another Hospital and/or from appropriate peers, acceptable to the Chief and Credentials Committee must be supplied in the form of references. References must be submitted consistent with the process and forms required by Medical Staff Administration. This requirement is considered not applicable for individuals seeking appointment to the Active Referring or Referring Affiliated Health Care Professionals categories.

Members must also fulfill any applicable Departmental or Sectional specific criteria for reappointment.

#### 2.8 Health Status

In order to be eligible for initial or reappointment, applicants must attest to a satisfactory physical and mental health status and the ability to perform the requested privileges with reasonable skill and safety.

New Applicants and current medical staff must disclose any limitations with their current physical or mental health that affects, or has the potential to affect, their ability to safely exercise the requested privileges and may be required to undergo specific testing.

Additionally, new applicants and current medical staff members must provide sufficient documentation to evidence fulfillment of requirements for mandatory vaccinations and any other standard health testing consistent with medical staff policies in order to be or remain eligible for membership and privileges.

Applicants and current members who fail to comply will be considered ineligible until all requirements are fulfilled.

Current members who do not comply will be automatically terminated.

ARTICLE VIII, Section 3d outlines the consequences for failure to comply with health status requirements.

#### 2.9 Federal or State Health Care Programs

To be eligible for initial or continued appointment, practitioners must not currently be debarred, excluded or precluded by agreement or on an involuntarily basis from participation in Medicare, Medicaid or any other federal or state governmental health programs.

Databases made available by governmental agencies regarding debarment, exclusion, and preclusion due, but not limited to, fraud, program abuse or other sanctions or actions are queried at the time of initial appointment and reappointment to the Medical Staff as well as on a monthly basis.

These databases include, but are not limited to the following: Office of the Inspector General (OIG), General Services Administration (GSA), Office of Foreign Asset Control (OFAC), Centers for Medicare and Medicaid Services (CMS), and the State of Connecticut Department of Social Services (DSS).

Processing of applications for practitioners who are identified and verified with the source organization as debarred, excluded or precluded during the course of initial appointment will cease and be automatically deemed voluntarily withdrawn. No hearing rights will be afforded.

ARTICLE VIII, Section 3c outlines the consequences of actions taken against current Medical Staff members relative to participation in federal or state governmental health care programs.

#### 2.10 Insurance Coverage

Medical Staff members must continuously maintain valid and sufficient malpractice insurance that will cover their practice at the Hospital in not less than the minimum amounts as from time to time may be recommended by the President and Chief Medical Officer following review by the Medical Executive Committee and approval by the Board of Trustees, or provide other proof of financial responsibility in such manner as the Board of Trustees may from time to time establish.

In the event of a lapse of a policy or a change in carrier, Members are obligated to obtain tail insurance, or the new policy must be fully retroactive in terms of coverage, so that the individual remains fully insured at all times.

Members are responsible for immediately notifying the Medical Staff Administration department, in writing, of any lapse in coverage (including any uninsured tail coverage period), reduction in coverage below Hospital required amounts and/or change in carrier.

Evidence of appropriate coverage must be immediately available or made immediately available upon request at all times and a complete claims history must be provided at the time of initial and reappointment.

ARTICLE VIII, Section 3h outlines the consequences of failure to maintain malpractice insurance coverage.

#### 2.11 Response Time

Medical Staff members must be located close enough to the Hospital to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their hospitalized patients. This includes making arrangements to ensure that other current members of the medical staff with appropriate privileges have agreed to provide coverage in relevant hospital location(s) when the Medical Staff member is not available. Such coverage arrangements must be identified at the time of initial and reappointment.

Consistent with the responsibilities of the Department Chief for oversight and management of all clinical department functions, individual clinical leaders may establish specific response times within which members of the Department must be available to be considered timely.

Based upon the requirements of the medical staff category to which they are appointed, some medical staff members may be required to fulfill responsibilities regarding emergency call and to provide other services as may be determined by the applicable Department.

#### 2.12 Continuing Education / Medical Staff Education

All members of the medical staff are required to participate in continuing medical education related to their area of practice to fulfill the continuing medical education expectations associated with maintenance of their license to practice in their profession.

At the time of reappointment, all members must attest to having, and being able to produce, if requested, evidence of continuing educational credits earned, as specified by current requirements of the individual's licensing body of the State of Rhode Island, Department of Public Health.

Successful completion of any Medical Staff Education training required at the time of initial and reappointment must be done for an application for initial or reappointment to be deemed complete. The appointment and privileges of Medical Staff who fail to complete Medical Staff Education training before their current appointment lapses will be automatically terminated. Under these circumstances, the Medical Staff member will be eligible for reinstatement once there is evidence that training has been successfully completed.

ARTICLE VIII, Section 3e outlines the consequences for failure to comply with the requirements related to continuing medical education or completion of medical staff education training.

#### 2.13 Medical Staff Dues.

The Medical Executive Committee shall establish the amount of medical staff dues to be collected and the categories of Medical Staff subject to payment of dues as well as the manner of expenditure of such funds.

Current members of the Medical Staff who are required, by virtue of appointment to certain categories, to pay medical staff dues are defined in Article IV.

Dues are collected annually at the end of each calendar year. Payment is due the first Monday in January and invoices shall be sent a minimum of thirty (30) days before payment is due. Medical Staff who are required to pay dues are notified by Medical Staff Administration. Medical Staff dues are not prorated for any reason. A second notice is distributed to those who have not paid by the first Monday in January and the relevant Department Chief shall be informed of any members of their Department who are delinquent in making payment.

Medical Staff members subject to dues payment are appropriately informed of the required response time and consequences for failure to pay dues in a timely manner as outlined in ARTICLE VIII, Section 3f.

#### 2.14 Contracted and Exclusively Contracted Services

In clinical services in which the Hospital contracts exclusively with a group for the provision of certain Hospital-based professional services and other contracted professional services, appointment to the Medical Staff and access to Hospital resources is restricted to physicians and any other practitioners, as applicable, who are members of the group under contract or who are designated by the Chief as an



extension of the group so as to enable the service to fulfill its obligations to the Hospital for patient care, education and research.

Where such exclusive contracts for professional services exist, continued appointment to the Medical Staff and clinical privileges are contingent upon the Member maintaining group membership with the contracted organization. In the event that group membership no longer exists, the Member shall be deemed to have automatically and voluntarily resigned from the Medical Staff.

Practitioners who are deemed ineligible to apply for appointment because they are not subject to an exclusive contract arrangement as described above or those who have been terminated because they are no longer appropriately associated are not entitled to a hearing under these Bylaws.

#### **Other Contractual Arrangements**

Notwithstanding any other provision of the Bylaws, or of the Rules & Regulations, the Hospital may require that membership and clinical privileges be contingent upon, and expire simultaneously with, other agreements or understandings or contractual relationships that are not exclusive. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws, Rules & Regulations and policies of the Medical Staff with respect to a hearing shall not apply.

The application of an individual whose specialty area of practice is one in which the Hospital has an exclusive or other contractual arrangement with a specific group and the individual is not a member of said group will not be processed and the applicant will be notified accordingly. This shall in no way be construed to be an action of the Medical Staff or be subject to Fair Hearing, appeal or appellate review under these Bylaws.

#### **2.15 Ethics and Professional Behavior**

All applicants and current Members of the Medical Staff are expected to demonstrate that they are able to work cooperatively and collegially with others to provide quality patient care. This includes adherence to the ethics of their profession, to the Yale New Haven Health System Standards of Professional Behavior and the Medical Staff Code of Conduct found in this Article, Section 8.

Since the date of initial licensure to practice his/her profession, applicants and current members must have never been convicted of any felony or misdemeanor relevant to Medical Staff responsibilities.

#### **2.16 Board Certification**

##### **Board Eligibility / Certification Requirements for Physicians, Dentists and Podiatrists**

Prospective Members of the Medical Staff must either (a) be currently certified by one of the U.S. specialty certifying boards as applicable to his/her practice and identified below or (b) have completed all of the relevant U.S. specialty board certification training requirements and, at the time the application is considered complete, consistent with these Bylaws, be considered by the relevant board as "eligible" to take the required examination(s) leading to Board Certification, or as eligible to do so after obtaining any Board required practice experience.

Current Members must remain board eligible by one of the U.S. specialty certifying boards identified below in order to remain eligible to be a member of the medical staff. This requirement is applicable to Members of all medical staff categories.

Members who are not certified at the time of appointment have five (5) years from the date of appointment to the Medical Staff by the Board of Trustees to achieve initial certification by the U.S. specialty certifying board applicable to his/her practice in order to remain eligible for membership and privileges. No hearing rights will be afforded for failure to meet board certification requirements.

If an applicant for initial appointment previously held certification from a U.S. specialty certifying board that has lapsed, but he/she remains eligible for recertification, he/she shall have three (3) years from the date of appointment to the Medical Staff by the Board of Trustees to achieve certification. If U.S. Board Certification is not achieved within such period, the member shall no longer be eligible for membership and privileges. No hearing rights will be afforded.

#### Board Re-Certification Requirements for Physicians, Dentists and Podiatrists

Members whose U.S. board certification bears an expiration date shall successfully complete recertification no later than three (3) years following such date in order to maintain appointment.

Members who were appointed prior to October 1, 2020 shall have five (5) years following expiration to achieve recertification in order to maintain appointment.

#### Exceptions to Board Certification Requirements

Under special circumstances at the discretion of the relevant Department Chief and Chief Medical Officer, an exception to the requirements for initial certification and recertification as described above may be requested. Such requests shall be made in writing and submitted to the Credentials Committee for consideration.

Exceptions may be recommended based upon: (1) board certification granted in another country that is determined to be equivalent to U.S. certification; (2) special clinical expertise held by the applicant and desired to support patient care or (3) unique educational contribution.

The Credentials Committee shall consider all exceptions and make its recommendation to the Medical Executive Committee (MEC). The Medical Executive Committee shall, in turn, consider the recommendation of the Credentials Committee and forward its own recommendation to the Patient Safety and Clinical Quality Committee of the Board of Trustees (PSCQ).

Foreign trained practitioners who are approved under any exception will be required to obtain certification by the appropriate U.S. board as identified below whenever the relevant board offers a pathway for them to become certified and, if applicable, under these circumstances, certification from the applicable U.S. board will be required within five (5) years of eligibility.

Exceptions will not be routinely granted and are not intended to serve as a precedent for any other individual.

#### Physicians

American Board of Medical Specialties (ABMS) certifying board  
American Osteopathic Board

#### Dentists

American Board of Oral & Maxillofacial Surgery  
American Board of Pediatric Dentistry  
American Board of Orthodontics

American Board of Prosthodontics  
American Board of Periodontology  
American Board of Endodontics  
American Board of Oral & Maxillofacial Pathology

Note: Dentists in the practice of general dentistry are exempt from requirements for board certification.

Podiatrists

American Board of Foot and Ankle Surgery (ABFAS) (formerly known as the American Board of Podiatric Surgery (ABPS)  
American Board of Podiatric Medicine (ABPM)

ARTICLE VIII, Section 3i outlines the consequences for failure to meet requirements for board certification.

1. Podiatrists: American Board of Podiatric Surgery, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or American Board of Podiatric Public Health

### **SECTION 3      ADDITIONAL REQUIREMENTS**

Practice History

At the time of application for appointment, each applicant shall answer “Practice History Information” questions contained in the application, which include whether or not the applicant:

- (a) been convicted of or charged with or pled guilty to any offense other than a minor traffic violation by any local, state or federal authority, official or agency or foreign/international equivalent thereof;
- (b) been denied any license, certification, narcotics permit, hospital appointment or privilege;
- (c) had any license, certification, narcotics permit, hospital appointment or privilege withdrawn, canceled, challenged, reduced, limited, not renewed, or relinquished, whether voluntarily or involuntarily;
- (d) been the subject of any disciplinary action including allegations related to any form of impairment, disruptive behavior or unprofessional conduct;
- (e) have any condition that would compromise his/her ability to practice with reasonable skill and safety; and
- (f) is currently engaged in illegal drug use or dependent upon any controlled substance or alcohol.

Information provided by applicants in conformance with this requirement shall be treated as confidential.

If any such actions were ever taken with respect to (1) through (6) above, details will be required as part of the initial appointment or reappointment process. Applicants must also provide information regarding any pending challenges, complaints, investigations, or other proceedings that might lead to any of the actions cited in this section. This information will be shared with the relevant Department Chief and the Credentials Committee.

#### **SECTION 4 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

The Medical Staff provides oversight of the quality of care, treatment, and services delivered by its Members who are credentialed and privileged through the Medical Staff process. The Medical Staff is also responsible for the ongoing evaluation of the competency of all who are privileged, delineating the scope of privileges that will be granted and providing leadership in performance improvement activities throughout the Hospital.

Each Member of the Medical Staff shall:

- a. Provide patients with care of the generally professionally recognized level of quality and efficiency;
- b. Discharge such staff, Department, service, committee and Hospital functions for which the Member is responsible by appointment, election or otherwise;
- c. Prepare and complete in timely manner, the medical and other required records for all patients for whom the Member has a responsibility;
- d. Demonstrate ability to work with and relate to other staff members, members of other health disciplines, hospital management and employees, the Board, in a professional manner that is essential for maintaining an environment appropriate to quality patient care and consistent with the Medical Staff Code of Conduct as outlined in Section 5; and
- e. Agrees to provide or arrange for continuous, appropriate and timely medical care for his/her hospitalized patients and to obtain consultation when indicated for the safety of his/her patient or when required by the rules or other policies of the Medical Staff, or the Hospital.
- f. abide by the Medical Staff Code of Conduct and Standards of Professional Behavior.

#### **SECTION 5 CODE OF CONDUCT**

The objective of the Code of Conduct is to encourage optimum patient care by promoting a safe, cooperative, respectful and professional health care environment and to eliminate any behaviors that disrupt Hospital operations, adversely affect the ability of others to competently perform their jobs or have a negative impact on the confidence of patients and families in the Hospital's ability to provide quality care.

For purposes of this section, this Code of Conduct applies to the interactions of Medical and Affiliated Health Care Professional Staff with other Medical and Affiliated Health Care Professional Staff, employees, patients and visitors.

The behavior of Members of and applicants for membership on the Medical Staff constitutes an essential component of professional activity and personal relationships within the Hospital. Civil department fosters an environment conducive to patient safety and quality. Consistent with the Code of Conduct, in

addition to the qualifications set forth elsewhere in these Bylaws, a Member of the Medical Staff shall at all times demonstrate an ability to interact on a professional and respectful basis with each other, Hospital staff, patients, visitors and to treat all persons with courtesy, respect and dignity.

The Code of Conduct is not in any way intended to interfere with a Member's right: (1) to express opinions freely and to support positions whether or not they are in disagreement with those of other Medical or Hospital staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development; (3) to engage in good faith criticism of others; or (4) to voice objection or concern about Hospital policies and procedures. It is, however, expected that all differences in opinion will be expressed in an appropriate forum and manner.

Every attempt shall be made to resolve violations of the Code of Conduct through education and collegial intervention. The PPEC shall be engaged as necessary in this process and issues handled via that Committee up to and including for cause Focused Professional Practice Evaluation as outlined in the Medical Staff Policy regarding FPPE. In addition to the Medical Staff process for addressing concerns, Members who are employed by Hospital shall also be subject to disciplinary action in accordance with Hospital progressive discipline policies.

#### PROHIBITIVE DISRUPTIVE CONDUCT

Unacceptable disruptive conduct is behavior that thwarts the accomplishment of the purpose set forth herein and may include, but is not limited to, the following behaviors:

- use of threatening, abusive or hostile language, comments or behaviors that belittle, berate, degrade, intimidate, demean and/or are threatening to another individual;
- statements or actions that are personal, irrelevant or go beyond the bounds of fair professional conduct;
- inappropriate physical contact or threats of physical violence or assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
- use of loud, profane, or similarly offensive language;
- derogatory comments or criticisms about the quality of care provided by the Hospital, another Medical Staff member, or any other individual made outside of an appropriate forum;
- impertinent or inappropriate comments (or illustrations) made in medical records or other official documents concerning the quality of care provided by the Hospital or another individual;
- willful disregard of Medical Staff and Hospital requirements, Policies and Procedures, failure to cooperate on assigned responsibilities or an unwillingness to work collaboratively with others;
- written or oral statements which constitute the intentional expression of falsehoods, or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others; and
- retaliation against any person who addresses or reports violations of the Code of Conduct.

Examples of serious violations of the Code of Conduct include, but are not limited to:

- deliberate destruction of any Hospital property
- possession of any unauthorized firearm or weapon

- gross immoral, fraudulent or indecent conduct
- Harassment: the Hospital prohibits all forms of unlawful and unacceptable harassment, including harassment due to race, religion, sex, national origin, age, marital status, sexual orientation and disability.

Sexual harassment is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subject to it or who witness it and is considered a serious violation of the Code of Conduct. Examples include, but are not limited to, the following:

- verbal: innuendoes, epithets, derogatory slurs, jokes, propositions, graphic commentaries, threats and/or suggestive or insulting sounds;
- visual: derogatory posters, cartoons or drawings; suggestive objects or pictures; leering and/or obscene gestures;
- physical: unwelcome physical contact including touching, interference with an individual's movement and/or assault;
- other: making or threatening retaliation as a result of an individual's negative response to harassing conduct

Violations of the Code of Conduct shall be referred to and reviewed by the Professional Practice Evaluation Committee (PPEC) and referred to the Credentials Committee as deemed appropriate.

## **SECTION 6 DURATION OF APPOINTMENT**

Appointments to the Medical Staff and granting of clinical privileges are not to exceed a period of three years.

## **SECTION 7 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**

### **7.1 Initial Appointments**

Practitioners granted clinical privileges at initial appointment are subject to routine Focused Professional Practice Evaluation (FPPE) consistent with Medical Staff policy. Performance shall be evaluated by the Department Chief or the Chief's designee. The FPPE for individuals who are members of the Affiliated Health Care Professional staff shall be conducted by the responsible supervising or collaborating physician or other appropriately qualified Practitioners delegated to do so by the Chief or supervising/collaborating physician.

### **7.2 Modification in Staff Category and Clinical Privileges**

The Medical Executive Committee may recommend to the Board a change in category of a current Medical Staff member or granting of additional privileges. All new privileges for current members of the Medical Staff shall be subject to Focused Professional Practice Evaluation (FPPE) consistent with Medical Staff Policy.

## **SECTION 8 LEAVES OF ABSENCE**

A leave of absence from the Medical Staff may be either: (1) requested by a Member or (2) activated by the Chief Medical Officer.

A leave of absence is defined as a period of time during which the member's membership and clinical privileges are temporarily inactive. During the period of a leave, the member may not exercise clinical privileges at any Hospital inpatient or outpatient setting, provide care via telemedicine link or hold office or other positions. All other membership rights, duties and obligations shall also be inactive.

#### 8.1 Leaves of Absence Requested by Members

Members typically request leaves of absence for, but not limited to, the following reasons: personal health or mental health concerns or health concerns of the medical staff member's family; maternity/paternity leave; practice relocation, or military duty.

The request for a leave must include the reason for the leave, the start date and anticipated return date. The period of time for a leave of absence may not initially exceed one year. A leave of absence may be renewable upon written request by the Medical Staff member, up to a maximum of three years.

If a Member's current Medical Staff appointment is due to expire during a leave of absence, the Medical Staff Member must, during the leave, apply for and meet the requirements for reappointment or else membership and clinical privileges shall lapse and the member deemed to have voluntarily resigned at the end of the current appointment period. If the member subsequently wishes to rejoin the Medical Staff, he/she shall be required to reapply in accordance with the process specified in ARTICLE VI for application for initial appointment.

#### 8.2 Return from Leave of Absence

In order to request a leave of absence, the Medical Staff member must personally submit a written or email notice to the Department Chief and Chief Medical Officer, copied to Medical Staff Administration. Medical Staff members are expected to request a leave any time they are away from Medical Staff or patient care responsibilities for longer than thirty [30] days due to circumstances which affect, or have the potential to affect, their ability to care for patients safely and competently.

#### 8.3 Leave of Absence Activated by the Chief Medical Officer

At any point after becoming aware that a Member of the Medical Staff is away from patient care responsibilities or due to circumstances which affect, or have the potential to affect, the ability to care for patients safely and competently, the Chief Medical Officer may automatically place a member on leave of absence. The Chief Medical Officer may consult with the Department Chief and other medical staff leaders or the Medical Staff Health Committee as deemed necessary.

#### 8.4 Approval of Leave of Absence

The Chief Medical Officer or his/her designee approves all leaves of absence and their duration. As a matter of routine, approved leaves of absence are reported along with other routine medical staff changes to the Credentials Committee, Medical Executive Committee and Board of Trustees or Patient Safety and Clinical Quality Committee of the Board of Trustees.

#### 8.5 Notification

All Medical Staff members placed on leave will be informed in writing or via email of the granting of a leave of absence including the approved duration and any specific requirements regarding the process for return.

#### 8.6 Return from a Leave of Absence

In order to return from leave of absence, a Member must request to do so personally in writing via a letter or email to the Department Chief and Chief Medical Officer, copied to Medical Staff Administration. All

applicable eligibility requirements as identified in Article III must be fulfilled in order to return from leave of absence.

The Department Chief and Chief Medical Officer approve returns from leave of absence. Based upon circumstances, the Chief Medical Officer may invoke review by the medical staff health committee or other medical staff committees before approving return from a leave of absence in order to assess whether the Member is able to exercise the required privileges with reasonable skill and safety.

If the leave of absence was for personal physical (except for maternity leave) or mental health or other health conditions, the request for reinstatement must be accompanied by a report from the individual's physician or, as applicable, treatment facility or program, indicating that the individual is capable of resuming a hospital practice and there are no conditions which have or have the potential to affect the member's ability to care for patients safely and competently. The member must execute any release(s) requested by the relevant medical staff leaders to facilitate communications with the individual's physician (or, if applicable, treatment facility or program) to adequately assess his or her ability to resume safe practice.

Practitioners who are on leave of absence for reasons not related to their own personal physical or mental health conditions may be required to provide a statement regarding the activities in which they were engaged while on leave of absence if deemed appropriate by the Department Chief, Chief Medical Officer or his/her designee.

Applicable State licensure, DEA and state controlled substance registration and professional liability insurance coverage must be current and any reappointment application materials must be received in order for the Member to return from a leave.

Appropriate references may be required in order for Members who practiced medicine in any capacity during a leave of absence. When required, such references must be submitted and deemed satisfactory before the Member's leave is terminated.

#### 8.7 Failure to Request Renewal of Leave or Reinstatement/Return from Leave of Absence

Failure to request renewal of a leave at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments.

Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

#### 8.8 Systemwide Notification

For members who hold Medical Staff appointments at more than one Yale New Haven Health System Affiliated Hospital, information concerning leaves of absence will be shared among the relevant Hospitals.



## SECTION 9 CONFLICTS OF INTEREST

The below serves as a guideline for the disclosure of and resolution of potential conflicts of interest of any Medical Staff Members serving Medical Staff and Hospital Committees.

Elected officers, Department Chiefs, and any other Members appointed or elected to committees have a fiduciary obligation to represent the highest interests of the Medical Staff in upholding the quality of care provided at the Hospital.

It is important that Members of committees be cognizant of potential conflicts of interest that may arise from their personal affiliations, activities, or compensation.

The chairs of all committees, including ad hoc task forces, are encouraged to consider and discuss potential conflicts of interest. Standing committees shall use the following guidelines of disclosure:

- a. Committee members shall disclose the existence of:
  1. Their ownership or the ownership of a member of their immediate family of material financial interests in any company that furnishes goods or services to the Hospital or is seeking to provide good or services to the Hospital;
  2. Any honoraria, speaker's fees, research grants or funding, or consulting fees (for example, from a pharmaceutical company or a managed care organization);
  3. Personal compensation from the Hospital especially if pertinent to discussion of certain programs or proposals;
  4. Participation with other organizations with potential conflicts of interest (e.g. other hospitals, health insurance companies, competing private healthcare businesses);
  5. Other personal relationships, activities, or interests which may inappropriately influence decisions or actions; and/or
  6. Gifts, including goods and services or honoraria, from vendors who sell to the Hospital. (Note: An "honorarium" or a payment for consulting services is a gift in whole or part unless it can be demonstrated that the recipient provided services of an equivalent value.)
- b. Members of the following standing committees shall make an annual disclosure by questionnaire to the relevant Chair/s and will make disclosures as appropriate during individual meetings:
  1. Medical Executive Committee
  2. Pharmacy and Therapeutics Committee
  3. Department of Surgery
  4. Credentials Committee

Ad hoc committees and other standing committees shall decide at the first meeting, and annually thereafter, if an annual disclosure by questionnaire will be required.

- c. A general requirement that committee members with any potential conflicts of interest be excused from discussion of an issue may diminish the ability of the committee to have full, informed debate. If a Member's ability to render a fair and independent decision is jeopardized by the conflict of interest, the Member should ask to be excused from discussion and/or vote. If a Member does make such a request,

and the majority of the other committee members believe that the Member should be excused from discussion or vote, the chair shall require the member to do so.

- d. If a Member discloses a potential conflict of interest and seeks a deliberation as to whether abstention from participation in discussion or vote is warranted, he/she should leave the room while the remaining members determine whether a conflict of interest exists.
- e. If a committee member has reasonable cause to believe that another Member has failed to disclose a potential conflict of interest, such member shall inform the chair who shall provide an opportunity for the Member in question to address the committee about the expressed concerns. The committee shall then deliberate as above. Any Member who is required to request to be excused from participation in deliberations will be given an opportunity to appeal to the committee in person.
- f. The minutes of the relevant meeting shall include the names of persons excused for conflicts of interest and whether any discussion of potential conflicts of interest occurred. The nature of the conflict shall also be identified in the minutes.

#### **ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF**

The Medical Staff shall consist of physicians, dentists and podiatrists. Members shall be appointed to one of the following categories:

1. Active Attending
2. Active Referring
3. Courtesy
4. Consulting
5. Telemedicine
6. Honorary

The “Active Attending” and “Active Referring” categories shall, collectively, be considered “Active Staff”.

#### **SECTION 1 ACTIVE ATTENDING STAFF**

Active Attending is an Active Staff category which shall consist of selected physicians, dentists, and podiatrists who demonstrate substantial commitment to the welfare and programs of the Hospital as well as its purposes, objectives and mission.

The obligations of members of the Active Attending Staff shall include the following:

- a. utilization of the Hospital as a principal site of hospital practice by actively participating in caring for patients at the Hospital (a physician, dentist or podiatrist may also be deemed to have utilized the Hospital as a principal site of practice during any period in which the practitioner has made a reasonable, good faith effort to do so);
- b. maintain an office or practice close enough to the Hospital to provide continuing care to patients and to assure availability within a reasonable time frame when a patient’s condition requires prompt attention; each Department or Section shall determine specific timeframes required;
- c. eligible for admitting, consulting and any other privileges for which they are qualified;

- d. demonstration of a willingness to participate in teaching programs;
- e. demonstration of a willingness to serve on committees, boards, or in administrative positions;
- f. must assume responsibility for call and/or consultation or to provide other services as requested by the relevant Department or Section Chair consistent with applicable Medical Staff Policies and Rules & Regulations;
- g. demonstration of a willingness to contribute to medical staff activities such as, but not limited to, quality review programs, teaching conferences, risk management and utilization management as requested by the relevant Department or Section Chair;
- h. demonstration of a willingness to have patients participate as part of teaching;
- i. demonstration of a willingness, with the concurrence of both the patient and the physician, to participate in research efforts,
- j. participation in Departmental and Sectional meetings including quality review programs and teaching conferences; and
- k. pay medical staff dues

The rights of members of the Active Attending Staff shall include the following:

- a. may vote in Medical Staff elections, on adoption or amendment of the Bylaws and associated Rules & Regulations and on issues presented at any meetings of the Medical Staff, or Department, Section or Medical Staff Committees of which he or she is a member consistent with the requirements of these Bylaws;
- b. eligible for election to serve as a Medical Staff Officers consistent with the requirements of Article X;
- c. eligible to serve in departmental and sectional leadership roles as further defined in these Bylaws;
- d. eligible to serve as Members of the Medical Executive Committee as applicable and further defined in Article XII, Section 9;
- e. eligible to be a voting member or Chair of any medical staff committee;
- f. may, after serving for a period of time designated by each Department, request exemption from certain departmental responsibilities consistent with any relevant Departmental or Medical Staff Policy including, but not limited to, taking call, by making such request to the relevant Department Chief and upon approval by the MEC;
- g. will be granted priority access to resources of the Hospital including, but not limited to, procedure rooms, operating rooms and beds when access becomes restricted due to high census or utilization
- h. Must meet the following requirements for "minimum contact":  
For purposes of this Section, a "contact" may occur on an inpatient or outpatient basis and includes the following:

1. an admission
2. a major surgical or other procedure
3. a consultation in a specialty area required by the patient's condition or by Medical Staff or Hospital rules.

In evaluating Active Medical Staff Members for reappointment, the minimum required number of contacts is an average of twelve (12) per year. Application for exceptions to minimum levels may be made for certain specialties and may be granted by the Board on the recommendation of the Department Chief and following consideration by the MEC.

## **SECTION 2. ACTIVE REFERRING STAFF**

Active Referring is a membership-only, Active Staff category that shall consist of selected physicians, dentists and podiatrists who are not clinically active in the Hospital inpatient or outpatient setting and will not serve as the responsible Attending physician for hospitalized patients. Members of this category are expected to maintain a commitment to the clinical, educational and/or community service mission of the Hospital and typically include primary and ambulatory care practitioners and others who will access Hospital services and facilities for their patients by referral for admission and care.

Practitioners qualify for Active Referring status by:

- a. maintaining an active ambulatory practice and utilizing the Hospital facilities for their patients;
- b. maintaining a strong relationship with the Hospital through participation in formal Hospital Committees or administrative functions that support patient care when asked to participate; and
- c. demonstrating a willingness, as appropriate, based on practice capacity and payor participation, to accept the referral of patients who do not have a relationship with a primary care or other relevant outpatient provider for outpatient care upon their discharge from the hospital or emergency department

Members of this category must meet the basic qualifications outlined in these Bylaws with the exception of any requirements related to hospital patient care activity.

Members of the Active Referring category:

- a. do not hold clinical privileges and may not provide any clinical care to patients in any Hospital inpatient or outpatient setting but may, ultimately, by ordering such studies in the Hospital's electronic medical record, refer patients to a Hospital facility for outpatient laboratory, radiologic or other outpatient studies or services as permitted by Hospital policy;
- b. may not write/enter orders or progress notes or give verbal or telephone orders to direct the care of hospitalized patients (except as noted in a. above);
- c. are encouraged to follow their patients when hospitalized under the care of another physician and to participate in that care by offering any pertinent information via the electronic medical record or personal communication with the responsible practitioner to support the care while the patient is hospitalized and/or post-discharge;
- d. may visit their hospitalized patients socially and view their medical records;

- e. must have appropriate training on the electronic medical record in order to use it to communicate via “Staff Messaging” with the practitioners responsible for the patient while hospitalized;
- f. may attend and participate in Departmental and other Hospital meetings including educational meetings such as Grand Rounds and other CME activities;
- g. are eligible to vote in medical staff elections, on adoption or amendment of Medical Staff Bylaws, Rules and on issues presented at Medical Staff or Departmental Committee meetings;
- h. are eligible for election to serve as a Medical Staff Officer;
- i. are eligible to serve on any Medical Staff Committee;
- j. are required to pay Medical Staff dues; and
- k. are exempt from Ongoing Professional Practice (OPPE) and Focused Professional Practice Evaluation (FPPE)

Members of the Active Referring category who wish to resume or begin Hospital-based practice or care for patients at any Hospital inpatient or outpatient location are eligible to apply for clinical privileges. Consistent with applicable Medical Staff Rules and Policies, if approved for privileges, training on the Hospital’s electronic medical record system appropriate to the area of practice must be completed before participating in patient care at any Hospital facility.

Requests for clinical privileges will be reviewed individually relative to evidence of current competence and consistent with the relevant sections of these Bylaws. Proctoring may be required.

### **SECTION 3      CONSULTING STAFF**

The Consulting Staff shall consist of selected physicians, dentists and podiatrists with specialized clinical expertise that is deemed desirable for patient care and/or student and trainee education at the Hospital.

Consulting Staff members do not meet the requirements for Active Attending staff appointment relative to utilizing the Hospital as a principal site of hospital based practice and do not have to meet the requirements geographic or any other office location requirements.

Members of the Consulting Staff:

- a. have an active staff appointment and privileges at other hospital/s except with permission by the CMO and under unique circumstances involving practitioners with special expertise;
- b. may or may not have an established practice within the Hospital community;
- c. are eligible for privileges for which they are qualified;
- d. if granted surgical privileges, serve as the responsible attending in surgical cases and responsible for providing or arranging appropriate patient coverage;
- e. may attend meetings of the Medical Staff and their department;

- f. are not eligible to vote at any meetings or serve as medical staff officers except with permission by the CMO and under unique circumstances involving practitioners with special expertise; and
- g. do not pay Medical Staff dues

#### **SECTION 4 TELEMEDICINE STAFF**

The Telemedicine Staff shall consist of physicians, dentists and podiatrists whose relationship with the Hospital is strictly limited to providing service via telemedicine and, therefore, never physically provide service to patients at any Hospital site.

Telemedicine is defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications for the purpose of providing patient care, treatment and services.

Teleradiology is a specific subset of telemedicine which refers to the practice of providing either official or preliminary readings of images solely through a telecommunications link.

In order to be eligible for appointment to the Telemedicine Staff category, a Member must eligibility requirements as stated in these Bylaws with the exception of those related to office location.

Members of the Telemedicine staff:

- a. may exercise such clinical privileges as granted but will never have primary responsibility for any patient;
- b. as possible, may attend meetings of the Department to which he/she is appointed but may not vote;
- c. may not serve as a Medical Staff officer, Department or Service Chief or Chair or member of any committee; and may not vote in Medical Staff matters;
- d. except as relevant to fulfill obligations in providing telemedicine services, are exempt from all responsibilities of emergency service care (call), consultation assignments, and clinic duties; and
- e. pay applicable Medical Staff dues

#### **SECTION 5 HONORARY STAFF**

The Honorary Staff shall consist of physicians, dentists and podiatrists who are retired from practice and are not active in the Hospital. Members of this category do not hold clinical privileges, are not required to undergo reappointment and are not required to maintain malpractice insurance.

Members of the Honorary Staff:

- a. are appointed for life and may be removed only for cause by the Medical Executive Committee;
- b. are not eligible to vote in any meetings or in medical staff matters including changes to the Bylaws and Rules & Regulations;

- c. may not serve as medical staff officers, Department or Division Chiefs or Chairs of any committees;
- d. may not serve on Hospital committees except with permission by the CMO under unique circumstances involving special expertise;
- e. may attend Medical Staff and Departmental meetings of an educational nature;
- f. may participate in Medical Staff social events; and
- g. do not pay Medical Staff dues

#### **ARTICLE V: AFFILIATED HEALTH CARE PROFESSIONALS (AHCP)**

Affiliated Health Care Professionals shall include the following: certified registered nurse anesthetists, advanced practice registered nurses, physician assistants, and clinical psychologists. Based upon the needs of the Hospital, other types of practitioners may be credentialed and privileged to this category upon recommendation of the Credentials Committee to the Medical Executive Committee and with approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees.

Individuals appointed in this category do not share in the rights of Medical Staff Members except as specifically outlined in these Bylaws. They are, however, subject to the same responsibilities and the same terms relative to provision of care and compliance with the Bylaws, Rules and Regulations and any applicable policies of the Medical Staff or Hospital.

Provisions relating to hearings, appeals and appellate review shall apply to Affiliated Health Care Professionals.

#### **SECTION 1 SUPERVISION**

Nurse anesthetists, nurse practitioners and physician assistants shall practice under the supervision, control, responsibility and direction of a physician member of the Medical Staff and required to have a supervising (or collaborating) physician who is a member of the Medical Staff.

Affiliated Staff in these professions may not exercise any clinical privileges without a supervising or collaborating physician and may only exercise privileges at the location(s) at which his/her supervising (or collaborating) physician is privileged to practice. In the event that a member of this staff who is required to have a supervising or collaborating physician is no longer sponsored by that physician, the member must immediately notify the Medical Staff Administration department, provide the name of the new supervising or collaborating physician or be deemed to have voluntarily resigned.

In the event that the supervising or collaborating physician becomes unexpectedly unavailable due to an emergency or another unforeseen circumstance for an extended period of time, one of or the alternative supervising or collaborating physician as identified in the written agreement shall assume responsibility until a permanent replacement can be confirmed.

A written supervising/collaboration agreement between a physician member of the Medical Staff and all nurse anesthetists, nurse practitioners and physician assistants is required. The agreements between a physician assistants and the supervising physician must be reviewed and renewed on an annual basis.

Supervision/collaboration shall be defined as the oversight of, or the participation in, the work of the member of Affiliated Health Care Professional including availability of direct communication either in person or by telephone.

The written supervising agreement shall define how alternate supervision by another appropriately privileged physician member of the Medical Staff shall be provided when the primary supervisor is unavailable.

## **SECTION 2 APPOINTMENT AND PRIVILEGING**

Wherever applicable, Affiliated Health Care Professionals are subject to all of the eligibility requirements and shall be appointed and privileged consistent with the processes for Medical Staff as identified in these Bylaws. Except for those who do not hold clinical privileges, individuals in this category shall be subject to the policies, procedures and requirements for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

Members in this category must have graduated from an accredited institution applicable to their profession and have and maintain certification and/or licensure by an appropriate body and, as applicable, in accordance with State of Rhode Island statutes.

Affiliated Health Care Professionals shall be appointed in at least one of the Departments of the Medical Staff. Each Affiliated Health Care Professional shall be appointed in the same Department and, as applicable, Division as his or her supervising or collaborating physician.

Certain members of the Affiliated Health Care Professionals Staff are authorized to conduct medical screening examinations as defined under federal law. These include physician assistants and nurse practitioners.

### **Affiliated Health Care Professionals:**

- a. may not serve as Medical Staff Officers or in any Medical Staff leadership roles as defined in these Bylaws;
- b. may not vote in Medical Staff elections or on changes to the Medical Staff Bylaws, Rules or Regulations, medical staff policies or other Medical Staff matters;
- c. may serve on Departmental and Hospital committees if requested and attend appropriate Departmental meetings;
- d. do not pay Medical Staff dues.

### **Referring Affiliated Health Care Professionals**

Affiliated Health Care Professionals who practice in an outpatient setting only and wish to apply for membership only (no clinical privileges) as Affiliated Health Care Professionals must be under the supervision, as required, of a member of the Medical Staff. Individuals in this category typically seek this status for membership strictly for clinical support reasons (e.g. including, but not limited to, access to Hospital electronic medical records, conferences and meetings) and may be appointed to the Referring Affiliated Health Care Professionals category.

Members of this category, by definition do not hold clinical privileges, and shall be exempt from Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) requirements.

## **SECTION 3 FAIR HEARING PROCESS FOR AFFILIATED HEALTH CARE PROFESSIONAL STAFF**

The Fair Hearing and Appellate Review Mechanism for Affiliated Health Care Professionals shall be as follows:

- a. Adverse decisions with respect to the denial of appointment or reappointment, the denial or removal of clinical privileges, or adverse action may be appealed by the individual to the MEC.



- b. If a decision is appealed, the Department Chief, or the Chair of the committee making the adverse decision, and the individual shall file written statements with the MEC.
- c. The MEC (or an ad hoc subcommittee of the MEC authorized by the MEC or its Chair to hear and decide the matter) may request to meet with the Chair and the individual. In the absence of such a request by the MEC or its authorized subcommittee, the individual shall have the right to such a meeting at his/her request.
- d. The decision of the MEC or its subcommittee shall be in writing and shall set forth the reasons for the decision. In the case of a subcommittee of the MEC, the report shall be presented to MEC for approval, modification, or rejection.
- e. The Chair or the individual may appeal the decision of the MEC to an ad hoc committee of the Board appointed by the Chair of the Board.
- f. In its sole discretion, the ad hoc committee of the Board shall establish a procedure to review the decision of the MEC, but at a minimum shall permit the Chair of the MEC and the individual to file written statements. The decision of the ad hoc committee of the Board shall be in writing and shall be final.
- g. The MEC and the ad hoc committee of the Board may establish reasonable time limits to implement the provisions of this section.
- h. No person with a conflict of interest shall serve as a member of a reviewing body under this sub-section.

## **ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

### **SECTION 1 GENERAL PROCEDURE**

The Medical Staff through its designated Departments, committees, and Officers shall evaluate and consider every application for appointment, reappointment, of physicians, dentists, podiatrists and Affiliated Health Care Professionals and each request for modification of membership status and shall transmit recommendations thereon to the Board. Practitioners appointed at other YNHHS affiliated hospitals with full clinical privileges may be appointed to the Telemedicine category by proxy in accordance with the YNHHS Telemedicine Policy.

Each recommendation concerning the appointment or reappointment of a member of the Medical or Affiliated Health Care Professional Staff and the clinical privileges to be granted shall be based upon whether the applicant meets the eligibility requirements as outlined in ARTICLE III, Section 2 along with any and all other requirements as outlined in these Bylaws.

### **SECTION 2 REQUIREMENTS FOR APPLICANTS FOR INITIAL APPOINTMENT AND REAPPOINTMENT**

- a. Individuals seeking initial appointment or reappointment must meet the eligibility requirements as outlined in ARTICLE III Section2.
- b. Those who are eligible shall complete and submit an appropriate application and provide any relevant supporting documentation as required for a complete application.

- c. **Acknowledgment and Agreement:** Applicants acknowledge receipt of and that they have read the Bylaws, Rules and Regulations of the Medical Staff and agree to be bound by the terms thereof. Additionally, if the applicant is granted membership and/or clinical privileges, he/she agrees to provide for continuous care for his/her patients.
- d. **Qualifications:** The applicant shall provide, or cause to be provided, sufficient information evidencing that he or she meets the qualifications as specified in these Bylaws. The relevant Department Chief, the Credentials Committee or its Sub-Committee, MEC, Board, or any individual designated on behalf of these persons or committees may also require additional information to appropriately assess the education, training and clinical competence for privileges requested, and/or qualifications for initial or continued membership. When such information can only be obtained from organizations or individuals that are not part of the Hospital, it shall be the responsibility of the applicant to provide or make available such information consistent with Section 4. Failure on the part of the applicant to provide, or cause to be provided, such information shall constitute a failure to complete an application for initial appointment or reappointment.

**Authorization to Obtain Information; Immunity.** Applicants acknowledge and agree that the Hospital and Medical Staff may seek, obtain, and use all information that it deems necessary to carry out their obligations under these Bylaws and Rules and Regulations and, with respect to employed Medical or AHCP Staff, for purposes of employment.

### **SECTION 3 EFFECT OF APPLICATION FOR INITIAL APPOINTMENT OR REAPPOINTMENT**

By applying for initial appointment or reappointment to the Medical Staff, the applicant:

- a. Signifies the willingness to appear for interviews in regard to the application and to furnish such additional information as may be requested.
- b. Authorizes Hospital representatives to consult with others who have been associated with the applicant or who may have information bearing on the applicant's competence and qualifications.
- c. Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of the applicant's professional qualifications and ability to carry out the clinical privileges the applicant requests as well as of the applicant's professional ethical qualifications for membership.
- d. Releases from any liability all Hospital representatives for their acts performed to the fullest extent permitted by law in connection with evaluating the applicant and the applicant's credentials.
- e. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for appointment and clinical privileges.
- f. For purposes of this Section the term "Hospital representative" includes the Board, its directors and committees; the President/CEO; Chief Medical Officer, all Medical and Affiliated Health Care Professional Staff members, Departments and committees, and employees and agents, including, but not limited to, those from other Yale New Haven Health System Affiliated Hospitals which have responsibility for collection or evaluating the applicant's credentials or acting upon the applicant's application; and any authorized representative of any of the foregoing.
- g. Agrees to execute additional authorizations/releases required to implement the provisions of this section.

#### **SECTION 4      COMPLETION OF THE APPLICATION / RESPONSIBILITY OF APPLICANTS**

All applicants are responsible for providing information deemed adequate for an appropriate evaluation of education, training, experience, current competence, ethics, personal qualities and qualifications to serve as an exemplary model for others and for resolving any doubts that arise regarding their qualifications during the initial appointment or reappointment process.

Applications will be considered complete when all questions on the required forms have been thoroughly answered, all supporting documentation (including full responses from reference writers) has been supplied and all information has successfully been verified through primary sources consistent with regulatory requirements and the requirements as outlined herein. A complete application may become incomplete if, during the credentialing process, it is determined that new, additional or clarifying information is required to confirm qualifications.

If an applicant for initial appointment or re-appointment fails to provide, or cause to be provided, any requested information, the application shall be deemed “incomplete” and processing will cease. If this occurs during a re-appointment and the applicant’s appointment lapses, he/she shall be considered to have voluntarily resigned from the Medical or AHCP Staff as applicable until/unless required documentation can be provided and the application approved in accordance with Sections 6 and 7 of this ARTICLE.

Any application for initial appointment or re-appointment that continues to be incomplete sixty (60) days after the applicant has been notified of additional information required will be deemed to have been voluntarily withdrawn.

Applicants for initial appointment and re-appointment attest that all statements, answers and information contained in their application and supporting documents are true, correct and complete to the best of their knowledge. Any misstatement or omission from the application is grounds to cease processing the application. The applicant will be informed of the misstatement or omission and permitted to provide a written response. If, upon review, a misstatement or omission is determined to be immaterial and/or unintentional, processing will resume.

Applicants for initial appointment and re-appointment attest that they understand that falsification, misrepresentation or omission of any material fact(s) will be sufficient cause for ceasing processing of an initial application or automatic relinquishment of appointment and privileges without the right to request a hearing or appeal.

#### **SECTION 5      APPLICATION PROCESS FOR INITIAL APPOINTMENT**

Additional information required for initial appointment:

The following shall be required for initial appointment in addition to the material outlined in Sections 2 and 3 above:

- a. References: Except as noted below for applicants who are presently appointed at another Yale New Haven Health System Affiliated Hospital, a minimum of three (3) references is required for all applicants. References must be from individuals in leadership (e.g. chief, section chief, medical director, supervising/collaborating physician) roles who have firsthand and direct information concerning the applicant’s practice and character and can provide an objective assessment as to the applicant’s performance in the six (6) areas of ACGME competency.

Specific guidelines as to requirements for references depending upon education and training as well as length of time in practice are incorporated into the application for initial appointment.

Based on information gathered in the application and in the course of the credentialing process, additional references may be requested and, if requested, shall be required in order for an application to be deemed complete. References will be requested via the process and form developed by Medical Staff Administration. References must be returned directly to Medical Staff Administration. Requirements for references for applicants who currently hold a medical staff appointment at a minimum of one other Yale New Haven Health System Affiliated Hospital are modified as outlined in the Policy entitled "Requirements for References for Crossover Practitioners."

- b. Professional Liability Insurance and Experience: Based on the information provided or obtained during the credentialing process, additional information pertaining to professional liability insurance and experience may be requested and shall be required for the application to be deemed complete.

## **SECTION 6      PROCESSING THE INITIAL APPOINTMENT APPLICATION**

- a. Verification of Information  
Applications for initial appointment shall be submitted to Medical Staff Administration, which shall, in timely fashion, solicit appropriate references and perform primary source and other verification of licensure and other qualifications as required by The Joint Commission. All verifications shall be through a primary source whenever possible or through a source approved by The Joint Commission as satisfying the requirement for primary source verification. Medical Staff Administration shall promptly notify the applicant about any difficulty in collecting and/or verifying required information.
- b. Transmission of Information  
Upon completion of processing, Medical Staff Administration shall transmit the application and all supporting documentation to the relevant Department Chief for review.
- c. Department Action  
Upon receipt, the Chief of each Department in which the applicant seeks privileges shall review the application and supporting documentation, whenever possible, conduct a personal interview with the applicant, and then transmit his or her recommendation regarding appointment, staff category, Department assignment and clinical privileges to the Credentials Committee. Any special conditions, as applicable, will also be communicated. Special conditions may be incorporated into the Focused Professional Practice Evaluation (FPPE).

A Department Chief may request additional information as he/she deems appropriate to assist in the evaluation of the candidate in order to make a recommendation. Under these circumstances, the application shall become incomplete consistent with Section 4 and is returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information required for completion of the application.

- d. Credentials Committee Action  
The Credentials Committee or its Sub-Committee shall review the application, the supporting documentation, review the Department Chief's recommendation, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the category and clinical privileges requested. In addition, the Credentials Committee may determine that more information is needed in order to make its recommendation. In this case, an application becomes incomplete and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion of the application pursuant to Section 4 of this ARTICLE. Once satisfied it has sufficient information, the Credentials Committee shall then communicate its recommendations as to appointment, category, Department and clinical privileges to be granted and any special conditions associated with the appointment to the MEC.

The Credentials Committee may recommend an appointment of less than three (3) years to the MEC. Typically, this will occur if information obtained in the credentialing process suggests that there may be concerns about the practitioner's performance or qualifications that are not of significant magnitude to deem the applicant ineligible for appointment and privileges but warrant a period of initial monitoring. In such cases, the requirements and expectations shall be articulated as part of routine FPPE and the applicant notified accordingly of such expectations and consequences of not fulfilling them in the manner or timeframe outlined.

e. Medical Executive Committee Action

At its next regular meeting following receipt of the Credentials Committee recommendations, the MEC shall consider the recommendations of the Credentials Committee. In addition, the MEC may request additional information from the applicant that the Committee deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion pursuant to Section 4 of this ARTICLE. The MEC shall then forward its recommendations to the Board including category, Department and clinical privileges recommended to be granted and any special conditions to be attached to the appointment.

1. Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Committee shall promptly forward it to the Board.
2. Unfavorable Recommendation: When the recommendation of the MEC is unfavorable in whole or in part, the unfavorable recommendation will be considered an adverse action. In such cases, the applicant shall be entitled to the Fair Hearing Process as set forth in ARTICLE XVIII for physicians, dentists and podiatrists and ARTICLE V, Section 6 for Health Professional Affiliates.

f. Appointments of Less than Three Years:

The MEC may recommend an appointment of less than three (3) years to the Board under the circumstances described in Section 3.d above. The recommendation for an appointment of less than three (2) years is not considered adverse.

g. Board Action

1. On Favorable MEC Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. The applicant shall be promptly informed in writing of the Board's action by a mechanism that will allow for confirmation of receipt to be secured. If the Board rejects a favorable recommendation of the MEC, this shall be deemed an adverse action and entitle the applicant to a Fair Hearing pursuant to ARTICLE XVIII for physicians, dentists and podiatrists and ARTICLE V, Section 6 for health professional affiliates.
2. In addition, the Board may request additional information from the applicant that the Board deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical

Staff Administration for continued processing. It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion pursuant to Section 4 of this ARTICLE.

### 3. EXPEDITED APPROVAL

- i. In the sole discretion of the Medical Staff, expedited board approval may be requested for the following medical staff actions:
  - Initial appointment to the Medical or AHCP Staff
  - Reappointment to the Medical or AHCP Staff
  - Granting of additional privileges to Medical or AHCP Staff

The authority to render this expedited decision may be delegated by the Board to a committee of at least two (2) voting members of the Board when the following criteria are met:

- The applicant meets all eligibility requirements as stated in ARTICLE III, Section 2
- The application for initial appointment, reappointment or granting of additional privileges has been deemed complete in accordance with Section 4;
- The Credentials Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges; and
- The MEC makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges.

An application is ineligible for this expedited process if any of the following has occurred:

- The application is incomplete; or
- The MEC makes a final recommendation that is adverse or has limitations.

Consistent with ARTICLE 3, Section 2.3, any applicant with a current challenge to his or her license in any state or whose membership at another hospital or health care facility has been subject to involuntary termination or privileges at another hospital or health care facility are subject to involuntary termination, reduction, restriction, denial or loss are not eligible for appointment.

Other situations in which expedited approval shall be evaluated on a case-by-case basis include, but are not limited to the following:

- There is a previously successful challenge to licensure or registration in any state; or
- The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant; or
- The Hospital Department Chief makes a recommendation not to approve or refuses to make a recommendation; or
- The applicant has prior arrests or convictions

#### h. Notice of Final Decision

The applicant shall be notified of the Board's decision by way of a letter copied to the relevant Department Chief which includes the following: (1) the staff category to which the applicant is appointed; (2) the Department to which the applicant is assigned; (3) the clinical privileges the applicant may exercise; (4) obligations and expectations concerning the Focused Professional Practice Evaluation (FPPE) process for new privileges and (5) any special conditions associated with the appointment.

i. Reapplication After Adverse Appointment Decision  
An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical or AHCP Staff until he/she is able to provide sufficient documentation evidencing that the concerns which led to the initial adverse decision have been addressed. A new application will be required and it shall be processed as an initial application.

j. Time Periods for Processing  
Applications for appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause or as otherwise provided for in these Bylaws, shall be processed within the time periods specified in this Section. Medical Staff Administration shall initiate the recommendation and approval process of applications by transmitting the application to the Department Chief upon confirming that the applicant has submitted all required information allowing the application to be deemed complete consistent with Section 4.

Applications eligible for Temporary Privileges consistent with Section 7, may be reviewed by the Credentials Committee Sub-Committee. All others shall be reviewed at the next regularly scheduled Credentials Committee meeting.

The MEC shall review the application and make its recommendation to the Board at the committee's next regularly scheduled meeting following the Credentials Committee.

The Board or, under circumstances involving Expedited Approval as outlined in Section 6.g.3, the appropriate committee thereof, shall then take final action on the application at its next regular meeting.

This time frame may be delayed if any of the committees or individuals responsible for reviewing an application pursuant to these Bylaws, and acting in good faith, deem that additional information is required to complete the application as provided for in this ARTICLE, or if circumstances beyond their reasonable control cause a delay.

l. Applicant Interviews  
Applicants for initial appointment shall be interviewed by the Chief of the Department(s) in which appointment is sought whenever possible, and at the sole discretion of the Credentials Committee, may be interviewed by the Credentials Committee, and by any other persons recommended by the Credentials Committee or the MEC. At the sole discretion of the Committee or individual responsible to conduct an interview, such interviews may be performed by phone to accommodate special needs of the individual conducting the interview, the Committee or the applicant.

## **SECTION 7 REAPPOINTMENT APPLICATION PROCESS**

The following shall be required for re-appointment in addition to the material outlined in Sections 2 and 3 above:

a. Satisfaction of eligibility requirements as outlined in ARTICLE III, Section 2

b. Completion of a Reappointment Application

At least one hundred and twenty (120) days prior to the expiration date of the present appointment of each Medical and AHCP Staff member, each member shall be provided with an application for reappointment.

Except for good cause, the application shall be completed and submitted to Medical Staff Administration at least ninety (90) days prior to the expiration date of the current appointment along with the items as outlined in Sections 2 and 3 above.

Failure to return the application, with all required information provided in sufficient time to allow processing and approval, shall be considered a voluntary resignation from the Medical or AHCP Staff at the expiration of the individual's current appointment.

In the event of a voluntary resignation due to failure to submit a complete application for re-appointment, as long as the reappointment application is returned with updated information within one (1) year of the resignation date, it will be accepted and processed. The applicant will be required to document activities that occurred during the period of the lapse in membership and privileges. Such documentation of activities may require verification and, depending upon the reason for the delinquency of the return, additional information may be required including, but not limited to references.

Members who fail to return a reappointment application within one (1) year of voluntary resignation will be required to complete an application for initial appointment.

c. Content of Reappointment Application

The reappointment application shall contain information necessary to maintain as current for the Medical or AHCP Staff member including, but not limited to, the following:

1. Any additional training, education and experience that qualify the applicant for the privileges requested;
2. Information about other hospital, health care organization or practice setting where the applicant provided clinical services during the preceding three (3) years;
3. An update regarding professional liability experience, including proof of appropriate insurance coverage and limits of liability;

d. Transmission of Information

Upon completion of processing, Medical Staff Administration shall transmit the application and all supporting documentation to the relevant Department Chief for review.

e. Department Action

The Department Chief shall review, among other things, the reappointment application as well as information about the applicant's activity at the Hospital including any available information from routine Ongoing or Focused Professional Practice Evaluation, Focused Professional Practice Evaluation conducted for cause (if applicable) and the applicant's peer review file. Information and references from external organizations as applicable shall also be considered.

All information pertinent to the Member's clinical competence to perform the privileges requested shall be considered in the recommendation of the Chief as well as the applicant's attendance and participation at relevant Departmental and Medical Staff meetings, assigned committee meetings and continuing education meetings.

The Department Chief may also request additional information as deemed necessary to appropriately assess qualifications for appointment and privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing consistent with Section 4. The Chief shall transmit his/her recommendation to the Credentials Committee as to whether the appointment should be renewed, renewed with a modified category and/or clinical privileges, or terminated.

The Department Chief shall have twenty (20) business days to make a recommendation. In the event that the Department Chief fails to provide his or her recommendation within twenty (20) business days of receiving a



complete application or withholds a recommendation, the application will be forwarded to the Credentials Committee for action.

f. Credentials Committee Action

The Credentials Committee shall review the application for reappointment, the supporting documentation, the Department Chief's recommendations, and such other information available to it that may be relevant to consideration of the reappointment of the applicant with the privileges that have been requested. The Committee may also request additional information as it deems necessary to appropriately assess qualifications for appointment and requested privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing.

It shall remain the applicant's responsibility to provide, or cause to be provided, any requested information which shall be necessary for completion of the application pursuant to Section 4 of this ARTICLE.

Once satisfied it has sufficient information, the Credentials Committee shall then communicate its recommendation as to reappointment, and if reappointment is recommended, category, Department and clinical privileges to be granted and any special conditions associated with the reappointment to the MEC.

The Credentials Committee may recommend a reappointment of less than three (3) years to the MEC. Typically this will occur if information obtained in the reappointment process identifies concerns not previously identified through Ongoing or Focused Professional Practice Evaluation or if re-appointment is concurrent with a for-cause Focused Professional Practice Evaluation. In such cases the practitioner will be notified and given an opportunity to meet with the Credentials Committee before its recommendation is forwarded to the MEC.

g. Medical Executive Committee Action

At its next regular meeting following receipt of the Credentials Committee recommendation, the MEC shall consider the recommendations of the Credentials Committee. In addition, the MEC may request information from the applicant that it deems necessary to make its recommendation regarding membership and clinical privileges. In the event that this occurs, the application shall become incomplete and is returned to Medical Staff Administration for continued processing. It shall remain the responsibility of the applicant to provide, or cause to be provided, any information necessary for completion consistent with Section 4 of this ARTICLE.

The MEC shall forward its recommendation to the Board as to whether appointment should be renewed, renewed with a modified category and/or clinical privileges, or terminated.

In the event that the recommendation of the MEC is adverse, in whole or in part, the final adverse recommendation shall not be made or forwarded to the Board for action until the applicant has been informed and offered the opportunity to request a Fair Hearing pursuant to ARTICLE XVIII or ARTICLE V, Section 6 (as applicable). The Board shall be apprised of these actions.

The MEC may also defer action for further discussion or consideration. The Committee may also request additional information as noted above in order to fully assess the applicant's qualifications.

h. Conditional Re-Appointment

In the event that the Credentials Committee or MEC requires additional time to consider an application for reappointment or an investigation or hearing is pending, a short-term conditional re-appointment may be recommended, pending the conclusion of the process. Conditional re-appointments are subject to the same requirements and are approved through the same process as all other re-appointments as outlined herein.

In such cases, the applicant will be notified and given an opportunity to meet with the relevant Committee. Any plan for monitoring or other criteria for regaining a three (3) year appointment will be discussed with the practitioner. This action is not considered adverse.

i. Board Action

Thereafter, the procedure provided in Sections 6.g shall be followed as closely as possible.

j. Time Periods for Processing

Transmittal of the reappointment application and its return shall be carried out in accordance with Section 7.a of this ARTICLE. Thereafter, and except for good cause, each person, Department, and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all recommendations concerning the reappointment shall have been transmitted to the Credentials Committee for its consideration and action pursuant to Article VI, Section 7.e, to the MEC for its consideration and action pursuant to Article VI, Section 7.f and to the Board for its action pursuant to Article VI, Section 7.h, all prior to the expiration date of the membership of the individual being considered for reappointment.

## **SECTION 8      REQUESTS FOR MODIFICATION OF STAFF CATEGORY OR CLINICAL PRIVILEGES**

A Member of the Medical or AHCP Staff, as applicable, may, either in connection with reappointment or at any other time, request modification of his/her staff category, Departmental assignment or clinical privileges by submitting the request in writing or via email to Medical Staff Administration. Requests shall be processed in substantially the same manner as provided in Article VI, Section 7 for reappointment.

## **ARTICLE VII: DETERMINATION OF CLINICAL PRIVILEGES**

### **SECTION 1      FOCUSED AND ONGOING PROFESSIONAL PRACTICE EVALUATION (FPPE AND OPPE)**

The Medical Staff shall establish and provide a systematic, consistent process to assure that there is sufficient information available to confirm the current competency of Medical and Affiliated Health Care Professional Staff in the granting of new privileges at the time of initial appointment, reappointment or between reappointment cycles and to address issues concerning the ability of these individuals to provide safe care. FPPE and OPPE provide the basis for obtaining Hospital-specific information of the current competency of all individuals holding delineated clinical privileges.

Medical Staff policies regarding FPPE and OPPE provide additional detail regarding these processes.

### **SECTION 2      EXERCISE OF PRIVILEGES**

Every physician, dentist, podiatrist and health professional affiliates who provides direct clinical services by virtue of Medical or Affiliated Health Care Professional membership shall, in connection with such practice and except as provided in Sections 5 and 6 of this Article, be authorized to exercise only those privileges or services specifically granted by the Board. No individual shall be required to perform an act which is in violation of his/her ethical, moral, or professional principles, standards, or good medical judgment.

### **SECTION 3      DELINEATION OF PRIVILEGES/ GENERAL**

a. Requests

Each application for appointment and reappointment to the Medical or Affiliated Health Care Professional Staff must contain a request for the specific clinical privileges desired by the applicant. A request for modification of privileges pursuant to ARTICLE VI, Section 8 must be supported by documentation of training and/or demonstrated clinical competence.

b. Basis for Determination of Clinical Privileges

Requests for clinical privileges shall be evaluated on the basis of the applicant's documented education, training, demonstrated clinical competence, and demonstrated ability and judgment. The basis for privilege determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance, patient contacts, and the documented results of the patient care audit and other quality maintenance activities required by these and the hospital corporate Bylaws to be conducted at the Hospital.

Clinical privileges granted or modified on initial appointment, reappointment, or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where the individual exercises clinical privileges. This information shall be added to and maintained in the Medical Staff file established for Medical and Affiliated Health Care Professional Staff. It shall be the applicant's responsibility to make such information available pursuant to Article VI, Section 4.

c. Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in ARTICLE VI.

d. Experimental or new procedures, treatment or instrumentation

Experimental drugs or experimental procedures may be administered or performed only after approval of the protocols involved by the Institutional Review Board. Any experimental procedure/treatment modality/instrumentation may be performed or used only after privileges have been granted through the process outlined in ARTICLE VI. For the purposes of this paragraph, new procedure/treatment modality instrumentation is one that is not an established procedure/treatment modality/instrumentation which is available and indicated on the current privilege delineation form of the relevant Department.

The relevant Department Chief shall be responsible for identifying procedures, treatment or instrumentation for which privileges may be granted and for recommending modifications, accordingly, to the privilege delineation. The privilege and associated required education, training, experience and other criteria shall be recommended by the Chief to the Credentials Committee for consideration. Once approved by the Credentials Committee, MEC and Board, individuals who meet the requirements as stated may apply.

#### **SECTION 4      LIMITATIONS OF PROFESSIONAL PRIVILEGES**

All Members and Affiliated Health Care Professional Members of the Medical Staff shall function within the scope of their approved delineated clinical privileges, with the understanding that it may not be safe or clinically appropriate to exercise all privileges in all Hospital sites or locations.

Notwithstanding this general rule, in an emergency, a Medical Staff or Affiliated Health Care Professional Member of the Medical Staff may perform any medical or surgical procedure permitted by his or her respective training and experience and Rhode Island license.

#### **SECTION 5      SPECIAL CONSIDERATIONS FOR DENTISTS, ORAL SURGEONS AND PODIATRISTS**

Requests for clinical privileges from oral surgeons, dentists and podiatrists are processed consistent with ARTICLE VI.

Surgical procedures performed by oral surgeons, podiatrists, and dentists are under the overall supervision of the Chief of the Department of Surgery. In all circumstances, a physician Member of the Medical Staff must perform

a basic medical appraisal on an oral surgical, podiatric, or dental patient, must determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When a significant medical condition is identified, the final decision on whether to proceed with the intended surgery must be agreed upon by the oral surgeon, dentist or podiatrist and the physician consultant. The Chief of the Department of Surgery makes a final determination if agreement cannot be reached.

## **SECTION 6      TEMPORARY PRIVILEGES**

Temporary privileges may be granted to a qualified candidate for Medical or Affiliated Health Care Professional Staff membership by the Chief Executive Officer or his designee under two circumstances as described below:

1. Complete, clean application pending approval; or
2. Urgent patient care need

Generally speaking, applicants with any of the following shall not be considered “clean” applicants and, therefore, ineligible for temporary privileges:

- Failure to meet eligibility requirements as stated in Article III, Section 2
- Previously successful challenges to licensure or registration in any state;
- Hospital Department Chief recommendation is not to approve or refuses to make a recommendation; or
- Pending or prior arrests or convictions for any reason

Consistent with ARTICLE III, Section 2.3, any applicant with a current challenge to his or her license in any state or whose membership at another hospital or health care facility has been subject to involuntary termination or privileges at another hospital or health care facility are subject to involuntary limitation, reduction, restriction, denial or loss are not eligible for appointment.

- a. On the occurrence of any event of a professional or personal nature which casts doubt on the candidate’s qualifications or ability to exercise the temporary privileges granted, the Chief Medical Officer, in consultation with the appropriate Department Chief may suspend or terminate temporary privileges.
- b. A candidate shall have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary privileges or termination of such privileges.
- c. In the event of any such termination, the individual's patients then in the hospital shall be assigned to another Practitioner by the Department Chief responsible for supervision. When feasible, the wishes of the patient shall be considered in choosing a substitute Practitioner.

In exercising temporary privileges, the applicant shall act under the supervision of the Chief of the Department to which the applicant is assigned. Temporary privileges shall not exceed 120 days and shall normally not extend past the date of the earliest Board meeting at which the applicant’s request for privileges can be acted upon.

Complete, clean application pending approval:

A candidate shall not be considered qualified for temporary privileges until the application for privileges is complete consistent with ARTICLE VI, Section 4 and a recommendation of the Department Chief has been received. Temporary privileges shall not extend beyond the period of the pendency of the application or 120 days, whichever is less. The Credentials Committee will be informed of all temporary privileges granted by its Subcommittee at its next regularly scheduled meeting.

### Urgent Patient Care Need

This is defined as circumstances in which the condition of a Hospital patient requires urgent or emergent care from a physician with special clinical expertise or training. Temporary privileges for urgent patient care need may not be invoked to accommodate scheduling conflicts or issues.

In cases of bona fide urgent patient care need, the Chief Medical Officer on the recommendation of the Department Chief and Credentials Chair, or their respective designees, may grant temporary privileges for a specified period of time. Such temporary privileges will be time limited specifically to the dates of the specific services the physician is asked to provide and, as applicable, the specific patient/s.

Individuals who are granted temporary privileges for an urgent patient care need must meet the minimum requirements for eligibility as listed below.

1. Evidence demonstrating that the applicant meets eligibility requirements as outlined in ARTICLE III, Section 2
2. Verification of license to practice in Rhode Island;
3. Verification of malpractice insurance to cover services provided at the Hospital;
4. Complete application to the Medical Staff specifying the privileges requested, dates and, as applicable, specific patients;
5. Verification of appointment and relevant clinical privileges at a Joint Commission (or equivalent) accredited hospital ;
6. Verification of completion of education and appropriate training;
7. Evidence of current competence and ability to perform the requested privileges with reasonable skill and safety as confirmed via the usual reference request form, written statement or a documented phone call from, at minimum, the Department Chief or individual in a position with direct knowledge of the applicant's performance at the applicant's primary hospital, National Practitioner Data Bank query;

### **SECTION 7      DISASTER PRIVILEGES DURING ACTIVATION OF THE EMERGENCY PREPAREDNESS PLAN**

Disaster privileges may be granted when the Emergency Preparedness Plan has been activated and the organization is unable to handle immediate patient care needs. The granting of such privileges shall be consistent with The Joint Commission standards and pursuant to the YNHHS Medical Staff Policy for "Granting Disaster Privileges."

Individuals granted emergency privileges under this provision are not considered to be Members of the Medical staff or applicants for membership.

**ARTICLE VIII: RESIGNATION, NOTIFICATION REQUIREMENTS, AUTOMATIC RELINQUISHMENT/SUSPENSION,  
SUMMARY SUSPENSION ACTIONS AND INVESTIGATIONS**

**SECTION 1      NOTIFICATION REQUIREMENTS**

a. Medical Staff Obligation to Report

All Members of the Medical or Affiliated Health Care Professional Staff are required to advise the Chief Medical Officer via Medical Staff Administration in writing immediately upon the occurrence any of the following:

1. any change in malpractice insurance coverage;
2. loss (other than for routine non-renewal), suspension, consent order or any other action (including censure, reprimand, probation, restriction and/or fine) taken regarding a professional license in Rhode Island or any other state;
3. loss (other than for routine non-renewal), suspension, consent order, restriction or any other action whether voluntary or involuntary taken with regard to state or federal authority to prescribe controlled substances;
4. loss (other than routine non-renewal or resignation of unused clinical privileges), suspension, reduction, resignation, relinquishment, limitation (or any other action arising out of concerns related to competence or professional conduct of membership or clinical privileges) at any other health care facility;
5. initiation of formal investigation at any other health care facility;
6. filing of a notice of exclusion/debarment from any federal health care program including Medicare or Medicaid, and
7. any arrest or the filing of any criminal charge (other than speeding violations and parking tickets) by local, state or federal authorities.

These reporting requirements are in addition to the information that is collected at the time of initial appointment and reappointment.

The circumstances surrounding any of the above occurrences, or failure to comply with the requirement to report them, will be evaluated individually in terms of pursuing disciplinary or other action. Practitioners whose appointment or all or a portion of clinical privileges are suspended as a result of failure to meet eligibility requirements related to any of the above are not eligible for a Fair Hearing.

b. Adverse Professional Review Actions, Investigations or For Cause FPPE

Medical and Affiliated Medical Staff members are required to report any adverse professional review actions, investigations or for cause FPPEs taken at other facilities. Continuation of medical staff membership and privileges for current members of the medical staff who become subject to any such actions at another hospital or health care facility shall be addressed as described below:

1. an adverse professional review action regarding appointment or clinical privileges for reasons related to clinical competence or professional conduct including, but not limited to, denial, revocation or suspension (excluding precautionary suspension) of membership or clinical privileges; or
2. any formal investigations or for cause Focused Professional Practice Evaluation (FPPE) pending resolution or completion at another institution; or

3. resigned appointment or relinquished clinical privileges during a Medical Staff investigation or in exchange for not conducting such an investigation at another institution

For any of the above actions taken at another Yale New Haven Health System Affiliated Hospital, the action taken by one Health System Affiliated Hospital shall be immediately and automatically applicable at any other Health System Affiliated Hospital as relevant to the practitioner's membership status and clinical privileges at that hospital.

For actions taken by a hospital that is not affiliated with Yale New Haven Health, the matter shall be immediately brought to the attention of the Chief Medical Officer and relevant department Chief for evaluation and determination as to the relevance to the practitioner's membership status and clinical privileges.

If currently privileged in the area of practice related to the action taken at the other hospital, related privileges shall be automatically relinquished pending review and recommendation by Credentials Committee, Medical Executive Committee and approval by the Board.

## **Section 2. AUTOMATIC RELINQUISHMENT, TERMINATION OR SUSPENSION**

The following outlines situations upon which Medical Staff membership and clinical privileges of a Medical Staff member are subject to automatic relinquishment, termination or suspension.

- a. **Licensure:** The following licensure actions shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:
  - i. Revocation, voluntary relinquishment or voluntary surrender or suspension of a license in any state;
  - ii. Agreement with a governmental entity not to exercise a license to practice;
  - iii. Permanent licensure restriction;
  - iv. Lapse of a license to practice in Connecticut due to failure to renew

In the event that privileges are automatically relinquished, the Member shall be notified in writing and alternate care coverage shall be provided for the Member's patients who remain in the Hospital. The desires of the patient should be considered. The relevant Department Chief shall be responsible for ensuring that such coverage is provided.

All other licensure actions, including, but not limited to, civil penalty, reprimand or censure, practice monitoring, proctoring or temporary licensure restrictions shall immediately be brought to the attention of the relevant Chief and Chief Medical Officer. In accordance with these Bylaws and relevant medical staff policies, the matter shall be forwarded to the Credentials Committee or Professional Practice Evaluation Committee for review and recommendation.

No hearing rights shall be afforded under circumstances leading to automatic relinquishment of membership and privileges related to licensure actions.

b. **Federal and State Drug Control Registration:** The following shall be cause for automatic relinquishment of clinical privileges and Medical Staff membership as of the effective date of the action:

- i. Agreement with a Federal or State governmental agency not to exercise a permit to prescribe controlled substances related to investigation by the agency; or
- ii. Surrender, revocation, suspension or limitation of a Federal DEA or State Controlled Substance certificate

No hearing rights shall apply under these circumstances.

Automatic relinquishment does not apply to the lapse or surrender of a Federal DEA or State of Connecticut Controlled Substance certificate under circumstances in which the member no longer requires the certificate to exercise clinical privileges and the member had not entered into an agreement not to prescribe related to an investigation.

c. **Federal or State Health Care Programs:** In the event that a current member of the Medical Staff is identified and verified with the source organization as debarred, excluded or precluded from participation in any federal or state health care program, the Chief Medical Officer and relevant medical staff leader will be immediately notified and the appointment and privileges of the Medical Staff member will be automatically terminated.

Practitioners who have been debarred, excluded or precluded from participation in a federal or state health care program for reasons having to do with the provision of health care services or care of patients such as, but not limited to, billing or other financial fraud, patient abuse or felonies will be permanently ineligible for appointment to the Medical Staff.

Practitioners debarred, excluded or precluded for other reasons may be eligible for reinstatement if fully reinstated with the relevant governmental entity subject to review and consideration of the circumstances surrounding the debarment, exclusion or preclusion by the Credentials Committee, Medical Executive Committee and Patient Safety and Clinical Quality Committee of the Board of Trustees.

Practitioners whose membership and privileges are automatically terminated related to debarment, exclusion or preclusion from federal health care program participation are not afforded hearing rights.

d. **Health Status:** Failure to comply with any health status requirements as outlined in ARTICLE III, Section 2 will result in automatic termination from the Medical Staff. Individuals who are automatically terminated for failure to comply with health status requirements are not afforded hearing rights.

e. **Continuing Education / Medical Staff Education:** Failure to attest to or provide evidence when requested of compliance with State of Rhode Island requirements for continuing medical education or failure to complete any required Medical Staff Education Training at the time of initial or reappointment will result in automatic termination of medical staff appointment and privileges. Hearing rights are not afforded under these circumstances.



- f. **Medical Staff Dues:** The membership and privileges of members who fail to pay Medical Staff dues within thirty (30) days of the second notice shall be considered automatically suspended. Membership may be immediately restored if payment is received within an additional thirty (30) days assuming that reappointment applications or any other required documentation has been submitted by the member. All others will be required to reapply in accordance with ARTICLE III of these Bylaws.

Medical Staff membership and privileges will be automatically terminated if dues payment has not been made thirty one (31) days following automatic suspension.

Members who are automatically terminated for failure to pay medical staff dues in a timely manner are not afforded hearing rights.

Members who have been approved for a Leave of Absence in accordance with Article III, Section 7 of these Bylaws may pay medical staff dues upon receipt of notice or upon return from Leave of Absence.

In addition to leave of absence, under extenuating circumstances acknowledged by the Medical Staff President, the Medical Executive Committee may consider and grant requests for extension of the deadline to pay dues.

- g. **Leave of Absence:** Failure to request renewal of a leave of absence at the end of the initial time period of the request, or to request reinstatement for the purpose of returning to practice at the end of a leave of absence within a minimum of two weeks shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges effective as of the end date of the leave. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointments. Hearing rights are not afforded under these circumstances.
- h. **Insurance Coverage:** Failure of a Medical Staff member to maintain professional liability insurance to the extent required by the Board of Trustees shall result in automatic suspension of the member's clinical privileges. If the Medical Staff member does not provide evidence of required professional liability insurance within thirty (30) calendar days after written warning of the delinquency from Medical Staff Administration, his Medical Staff membership shall be automatically terminated.
- i. **Board Certification:** Failure of a Medical Staff member to obtain or maintain board certification consistent with the requirements, as applicable, as outlined in ARTICLE III, Section 2 shall result in automatic termination. Hearing rights are not afforded under these circumstances.
- j. **Cooperation with Peer Review Activities:** As a matter of routine proceedings, the Professional Practice Evaluation Committee (PPEC) or the Credentials Committee may request that a member of the Medical Staff participate in a review of his/her own Hospital cases, aspects of Hospital based practice, or matters involving professional behavior. Clinical privileges and medical staff membership may be considered automatically relinquished for refusal to cooperate with such reviews when requested until the necessary input has been provided.

Under these circumstances, hearing rights are not afforded.

- k. **Notice:** Once it has been determined that a condition or circumstance exists warranting automatic suspension, the practitioner shall be notified of the automatic suspension. Such notification shall include the reason for the automatic suspension, the effective date of the automatic suspension, and the conditions under which such suspension shall be lifted.

Except for administrative suspension for failure to complete medical records, such notification shall be signed by the President or Vice President of the Medical Staff. If the President or Vice President of the Medical Staff is unavailable, the CEO or the CMO may issue the notification.

Except for the case of automatic suspension for Medical Records, the MEC shall be apprised of the automatic suspension at its next regularly-scheduled meeting. In the case of suspension for medical records, the Health Information Management Department may develop a process for the notification of practitioners, which process shall be approved by the MEC.

- l. Termination of Automatic Suspension: Unless otherwise provided for in this article and in the absence of any corrective action taken in association with an automatic suspension, the automatic suspension shall be terminated at such time as it is confirmed by the President of the Medical Staff, Vice President of the Medical Staff, the CEO, or the CMO that the circumstances causing the suspension no longer exist. In the case of automatic suspension for Medical Records, this determination may be made by the Department of Health Information Management.
- m. Continuous suspension of a medical staff member for three (3) months pursuant to this section, shall be considered a voluntary resignation from the Medical Staff and the member's Medical Staff membership shall be terminated.

### **SECTION 3 SUMMARY SUSPENSION**

Any one of the following shall each have the authority, whenever action must be taken immediately when failure to act may result in imminent danger to the health of any individual in the Hospital, to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff, and such suspension shall become effective immediately upon imposition:

- Chief Executive Officer
- Chief Medical Officer
- Department Chief
- MEC
- Patient Safety & Clinical Quality Committee of the Board
- the Board

Summary suspension shall be imposed under circumstances in which there is a risk of imminent danger to patients or the Hospital community and no other opportunity to mitigate that risk via collegial intervention or in voluntary cooperation with the Member.

A summary suspension is effective immediately upon imposition and the person or group imposing the suspension is to follow it up promptly by giving special notice of the suspension to the practitioner. Alternate medical coverage shall be provided for the Member's patients who remain in the Hospital. The desires of the patient should be considered. The Department Chief shall be responsible for ensuring that such coverage is provided.

Consistent with ARTICLE XVIII or ARTICLE V, Section 6, as applicable, in the event that all or a portion of the clinical privileges of a member of the Medical Staff have been summarily suspended, the member shall be notified and informed of hearing rights. Consistent with the terms of ARTICLE XVIII, after hearing the matter, the Hearing Committee may modify or terminate the suspension, or recommend that it continue. Following a Hearing, the Member who is the subject of summary suspension shall be entitled to appellate review in accordance with the provisions of the Fair Hearing Plan, ARTICLE XVIII or ARTICLE V, Section 6, as applicable. In the event that a summary suspension is upheld after completion or waiver of appellate review, unless provided otherwise in the final decision, the membership of the individual shall simultaneously terminate and there shall be no further right to a hearing or appellate review under these Bylaws.

#### Medical Executive Committee Review / Action

As soon as possible, but in any event within fourteen (14) days after a summary suspension is imposed, the MEC shall convene to review and consider the action taken.

The MEC may recommend modification, continuation or termination of the terms of the suspension.

A MEC recommendation to continue the suspension or to take any other action entitles the Member, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan outlined in ARTICLE XVIII or ARTICLE V, Section 6 as applicable.

A MEC recommendation to terminate the suspension or to modify it to a lesser sanction is transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed remain in effect pending a final decision by the Board.

#### **SECTION 4 GENERAL PRACTICE, COMPETENCY OR BEHAVIOR CONCERNS**

Staff appointments may be revoked, suspended, or limited for due cause, including, but not limited to:

- any condition that would compromise the ability of the individual to practice with reasonable skill and safety;
- failure to provide adequate patient care;
- exceeding the scope of an approved delineation of clinical privileges;
- failure to abide by these Bylaws, or the Rules and Regulations and policies of the Medical Staff or Hospital, including the Code of Conduct and approved policies of Departments and Committees.

When concerns are raised regarding a Member's clinical practice, if he/she demonstrates behavior that is inconsistent with the Medical Staff Code of Conduct (ARTICLE III, Section 8) or if he/she violates acceptable ethical standards or Medical Staff or Hospital Bylaws, policies or Rules & Regulations, a review of the matter and circumstances may be indicated.

These issues are generally evaluated by the Chief Medical Officer, the Department Chief or their designee. In some instances, following inquiry into the matter, a referral is made to the PPEC and that group or an individual it designates will address the matter with the Member. Every effort is made to address and resolve these issues at one of these levels through collegial intervention. The involved Member is notified of any concerns and participates in the process as outlined in the Medical Staff Policy regarding Routine and Ongoing Professional Practice Evaluation.

A for cause Focused Professional Practice Evaluation (FPPE) may also be undertaken and coordinated with the appropriate Department Chief consistent with the Medical Staff FPPE Policy.

## **SECTION 5      FORMAL INVESTIGATION**

### **a. Initiating a Formal Investigation**

Following unsuccessful documented attempts at collegial intervention at this level or in the event that there are concerns about a Member that are of a very serious nature, further inquiry may be initiated. After sufficient inquiry and validation that the issues identified are credible, the Chief Medical Officer, the PPEC, the MEC or the Patient Safety & Clinical Quality Committee of the Board may recommend a formal investigation to the Credentials Committee, MEC or Patient Safety & Clinical Quality Committee of the Board.

In addition, a Department Chief or Service Chief may also request that the Chief Medical Officer, PPEC, MEC or the Patient Safety & Clinical Quality Committee of the Board review a matter regarding a member of his/her Department for consideration of a formal investigation.

The Credentials Committee, Patient Safety & Clinical Quality Committee of the Board of Trustees or Medical Executive Committee considers the recommendation to initiate a formal investigation and, if they agree, formally commences an investigation by making a resolution to do so. Resolutions must be approved by a majority of those present and voting.

### **b. Investigation Committee**

The body identified to conduct the investigation shall be deemed to be the Investigation Committee.

The Committee that resolved to initiate the investigation may choose to serve as the Investigation Committee, may request that another Committee serve as the Investigation Committee or may appoint or request another Committee to appoint an Investigation Committee. The Investigation Committee may establish a sub-committee for the purpose of "fact-finding" in the investigation. The sub-committee reports its findings to the Investigation Committee.

None of the above shall be construed to limit the ability of the individuals authorized in Section 3 of this ARTICLE to summarily suspend all or a portion of the clinical privileges of a Member of the Medical Staff whenever such action must be taken immediately when there is a risk of imminent danger.

The Member in question is notified in writing of the formal investigation, the steps that will be taken during the investigation, his/her responsibilities, rights and options and that he/she will have an opportunity to participate in the process before any final determinations are made.

The Investigation Committee shall not include partners, associates or relatives of the individual being investigated and shall have the authority to review relevant documents and interview individuals with information pertinent to the matter at hand as well as the authority to use outside consultants, if needed. It may also require a fitness evaluations of the individual under investigation.

The individual under investigation shall have the right to meet with the Investigation Committee, be informed of the allegations against him/her that form the basis of the investigation and discuss, explain or refute the evidence presented.

The investigative process of this committee is not considered a fair hearing and, as such, the individual under investigation shall not have the right to be represented by legal counsel during the proceedings.

c. Recommendation of the Investigation Committee

At the conclusion of this process, the Investigation Committee shall submit its recommendation(s) to the MEC or Credentials Committee if the Investigation Committee is not the Credentials Committee. The individual under investigation is informed of the recommendation of the MEC.

If the recommendation is adverse and the MEC concurs in whole, in part or modifies a recommendation that remains ultimately adverse, the individual under investigation shall be entitled to a Fair Hearing as described in ARTICLE XVIII or ARTICLE V, Section 6 as applicable.

## ARTICLE IX: PROCEDURAL RIGHTS

### SECTION 1 DEFINITION OF ADVERSE RECOMMENDATIONS AND ACTIONS

Subject to the exceptions set forth below, the following recommendations or actions are deemed adverse:

- a. Denial of initial staff appointment
- b. Denial of reappointment
- c. Suspension of staff appointment, provided that summary suspension entitles the practitioner to request a hearing only as specified in Section 2.
- d. Revocation of staff appointment
- e. Suspension or limitation of the right to admit patients not related to the adoption or implementation of an administrative or medical staff policy within the Hospital as a whole or within one or more specific departments or failure to meet eligibility requirements.
- f. Denial or restriction of requested clinical privileges
- g. Reduction of clinical privileges
- h. Suspension of clinical privileges, provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection (n) of this Section 2.
- i. Revocation of clinical privileges
- j. Individual application of, or individual changes in, mandatory consultation or concurrent supervision requirement
- k. Summary suspension of medical staff appointment or clinical privileges, provided that the recommendation of the MEC or action by the Board is to continue the suspension or to take other action which would entitle the Practitioner to request a hearing under this Section 2.

### SECTION 2 PROCEDURAL RIGHTS

a. Adverse Action by the MEC

When a Practitioner receives notice of an adverse recommendation as defined above that has been made by the MEC he/she is entitled, upon timely and proper request, to a Fair Hearing in accordance with ARTICLE XVIII.

b. Adverse Action by the Board

When a Practitioner receives notice of an adverse decision made by the Board, he/she is entitled, upon timely and proper request, to a hearing in accordance with the procedures set forth in the Fair Hearing Plan as outlined in ARTICLE XVIII, so long as he/she has already not had a hearing in accordance with PART VI, Section 2.

### **SECTION 3      ACTIONS THAT DO NOT AFFORD HEARING RIGHTS**

Certain Actions or Recommendations: Notwithstanding any provision in these Medical Staff Bylaws to the contrary, the following actions or recommendations do not entitle a Member to a hearing:

- a. collegial interventions or coaching to address behavior or performance;
- b. implementation of routine or for cause Focused Professional Practice Evaluation (FPPE) which includes pre or retrospective review of cases but without a requirement for direct, concurrent supervision or for mandatory consultation;
- c. the removal of a Practitioner from an administrative role or position within the Hospital including contract and voluntary Department Chiefs;
- d. determination of ineligibility based on a failure to meet eligibility criteria as outlined in ARTICLE III, Section 2, lack of available resources as defined in ARTICLE III, Section 1.3, or because of an exclusive contract;
- e. determination that an application is incomplete;
- f. determination that an application will not be processed due to a misstatement or omission;
- g. Any actions that result in automatic termination as described in ARTICLE VIII, Section 3
- h. any other action or recommendation not listed in Section 1 above.

Other Situations: An action or recommendation listed in Section 1 above does not entitle the practitioner to a hearing when it is:

- a. voluntarily accepted and agreed to by the Practitioner as part of collegial intervention efforts,
- b. automatic pursuant to any provision of the Medical Staff Bylaws and / or having to do with eligibility or administrative requirements for ongoing Membership , or
- c. taken or recommended with respect to temporary privileges

### **SECTION 4      PROCESS FOR HEARING AND APPELLATE REVIEWS**

All hearings and appellate reviews will be conducted in accordance with the procedure and safeguards set forth in ARTICLE XVIII or ARTICLE V, Section 6 as applicable.

## **ARTICLE X: MEDICAL STAFF OFFICERS**

### **SECTION 1      OFFICERS OF THE MEDICAL STAFF**

The officers of the Medical Staff include the following:

- a. President
- b. President-elect
- c. Immediate Past President
- d. Secretary-Treasurer

### **SECTION 2      QUALIFICATIONS**

The following are required in order for a Member of the Medical Staff to be eligible to serve as an Officer of the Medical Staff:

- a. A Member in an Active staff category at the time of nomination and election and remain as such during the full term of office;

- b. Have demonstrated executive and administrative ability through experience and prior constructive participation in Medical Staff activities and be recognized for a high level of clinical competence;
- c. Have demonstrated a significant interest in and support of the Medical Staff and Hospital by virtue of tenure and level of clinical activity.
- d. Agree to and, if elected, willingly and faithfully discharge the duties and exercise the authority of the office held and work with the other officers and department leaders and with the Chief Medical Officer, Chief Executive Officer, the Board and its committees.

**SECTION 3      TERM OF OFFICE**

The term of office is two (2) medical staff years, subject to reconfirmation after the first year. Confirmation vote is to be by secret ballot. Officers assume office on the first day of the Medical Staff year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each officer serves until the end of this term and until a successor is elected, unless he/she resigns or is removed from office.

**SECTION 4      ELIGIBILITY FOR RE-ELECTION**

An officer is eligible for re-nomination and election to the position of President-elect after one year has passed since he/she held the office of immediate past president. The Secretary-Treasurer is eligible to succeed himself/herself in the same position.

**SECTION 5      ELECTION PROCESS**

President and Immediate Past President

The President is elected by automatic succession from the position of President-elect, subject to a confirmation vote at the annual staff meeting preceding his/her assumption of the office of President. This confirmation vote must be by secret ballot. The immediate Past President attains office by automatic succession from the office of President.

President Elect and Secretary - Treasurer

- a. Election: The President-elect and Secretary-Treasurer are chosen, subject to Board approval and from among the candidates nominated under paragraph (b) below, by election by majority vote cast by those members of the Active staff category at the annual meeting. Voting shall be by secret ballot. If no candidate for a given office receives a majority vote on the first ballot, a runoff election will be held immediately between the two candidates receiving the highest number of votes.
- b. Nomination: The Nominating Committee, as selected by the immediate Past President of the Medical Staff will convene prior to the annual meeting, at which an election of officers is to occur, for the purpose of nominating one or more qualified candidates for each of the offices of President-elect and Secretary-Treasurer. The list of nominees is then published prior to the annual meeting as the slate of officers. If, before the election, any of the individuals nominated either refuse, are disqualified from, or otherwise are unable to accept nomination, then the nominating committee may submit substitute nominees, or accept nominations from the floor by active staff members in good standing. Election of any officer nominated in this matter is subject to Board approval.

### Reconfirmation of Votes for Second Year of Terms

The incumbent in each officer position must be confirmed at the annual meeting prior to the start of the second year of the term, such confirmation to be accomplished in the same manner as original election except that formal nominations shall not be required and the incumbent officers must be confirmed by secret ballot vote. If an officer fails to be confirmed, a vacancy will be declared to exist in the office and will be filled as provided in Section 6 below.

## **SECTION 6 VACANCIES**

### President

A vacancy in the office of the President is filled by automatic succession of the President-Elect who serves the remainder of the unexpired term and his/her own full term as President.

### President- Elect or Secretary-Treasurer

A vacancy in the office of President-Elect or Secretary-Treasurer is filled by appointment of an acting officer by the MEC, subject to approval by the Board. The acting officer serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in Section 5, provided however that the MEC may determine not to call a special election if a regular election for the office is to be held within 180 days in which case the acting officer serves only until the election results are final and the individual then elected assumes office immediately.

### Immediate Past President

A vacancy in the office of Immediate Past President is filled for the remainder of the unexpired term by appointment by the MEC. Consideration should be given in filling the vacancy to prior staff Presidents.

## **SECTION 7 RESIGNATION AND REMOVAL FROM OFFICE**

### Resignation

Any officer may resign at any time by giving written notice to the Chief Medical Officer and the MEC. Such resignation takes effect on the date of receipt or at any later time specified in it.

### Removal

- a. By the Active Medical Staff

Grounds for removal: Permissible reasons for removal of an officer include, without limitation:

1. Failure to perform the duties of the position in a timely and appropriate manner.
2. Failure to continuously satisfy the qualifications for the position.

Removal of an officer by the Active Medical Staff may be effected by a two-thirds majority vote by secret ballot of Members of the Active staff category present at any regular Medical Staff or special meeting called for that purpose. A minimum of fifty (50) Active staff members must be present at that meeting. Any Active Member may move for the removal of any officer.

A letter to the President with a minimum of ten (10) cosignatories will initiate this. The President will promptly provide a copy of the letter to the officer and Chief Medical Officer. A vote must be taken at the next Medical Staff meeting occurring at least ten (10) days after notification of the officer. The officer who is subject to the removal action



shall be afforded the opportunity to speak in his/her own behalf, as applicable, prior to the taking of any vote on his/her removal.

b. Automatic Removal of an Officer

An officer will be considered ineligible to continue and automatically removed from his/her position under either of the following circumstances:

1. The individual is subject to an automatic or summary suspension.
2. A confirmed physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.

## **SECTION 8 DUTIES OF OFFICERS**

The responsibility and authority, including specific functions and tasks, of officers are as below:

President:

- a. The President is the primary officer of the Medical Staff and the representative of the Medical Staff in its relationships to others within the Hospital.
- b. In the absence of a specific chief quality officer, the President, in conjunction with the Professional Practice Evaluation Committee (PPEC) and MEC, shall fulfill these duties by working jointly with the Chief Medical Officer in coordinating and overseeing professional practice evaluation, risk management and utilization monitoring activities. Under these circumstances, the President shall advise the Chief Medical Officer and Board accordingly on these matters.
- c. The President is a member of the MEC, Professional Practice Evaluation Committee and Board with full voting rights.
- d. Transmits the views, recommendations and concerns of the Medical Staff to the Chief Medical Officer, MEC and Board accordingly regarding Hospital policy, planning, operations, governance, and relationships with external agencies.
- e. Coordinates with administration, nursing, support and other personnel and services. Enforces compliance with the provisions of the Bylaws, Rules and Regulations and related manuals, policies and procedures of the Medical Staff and Hospital with Members of the Medical Staff as related to these matters and with regulatory and accrediting agencies' requirements.
- f. Sets the agenda and Chairs the MEC and all general and special meetings of the Medical Staff.
- g. Subject to the approval of the MEC, appoints Chairs and Medical Staff members to Medical Staff committees formed to accomplish staff administrative, environmental or representative functions.
- h. Serves as an ex officio member of all other standing Medical Staff committees, with vote as indicated in the statement of the committee's composition.
- i. Reviews and enforces compliance with standards of ethical conduct and professional behavior among the Members of the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the Hospital community.

President Elect:

Whenever the President is unable, temporarily or permanently, to fulfill the duties of his/her office by reason of illness, resignation, removal or other absence, the President-elect will succeed to the office of

the president. The President-elect serves on the MEC and is also responsible for those duties delegated by the President or by the MEC

Secretary – Treasurer:

As Secretary of the Medical Staff, the Secretary-Treasurer is responsible for assuring that accurate and complete minutes of all meetings of the Medical Staff and of the MEC are kept. As Treasurer, the Secretary-Treasurer is responsible for supervising the collection of Medical Staff dues and assessments consistent with the requirements of ARTICLE III, Section 9 and accounting for all funds of the Medical Staff including providing an annual financial report for the annual meeting of the Medical Staff and any interim reports as requested by the President or the MEC. The Secretary-Treasurer serves on the MEC and is also responsible for such other duties as are delegated by the President or the MEC.

Immediate Past President:

The immediate past President serves as Chair of the Credentials Committee and acts as an advisor to the President and to other officials and committees of the Medical Staff. The Immediate Past President is a member of the MEC and shall perform such additional duties as may be assigned by the President or the MEC. The Immediate Past President shall also serve on Community Health of Westerly (CHOW) Board.

## **ARTICLE XI: CLINICAL DEPARTMENTS**

### **SECTION 1 CLINICAL DEPARTMENTS**

The clinical departments are as follows:

- Medicine
- Surgery
- Radiology
- Pathology and Clinical Laboratory
- Psychiatry
- Anesthesia
- Emergency Medicine.

### **SECTION 2 ESTABLISHMENT OF NEW CLINICAL DEPARTMENTS AND SERVICES**

The MEC may re-evaluate this clinical department structure and, as applicable, may recommend to the Board any action it deems appropriate in creating new, eliminating or combining departments and/or services for better organizational efficiency and improved patient care.

Action taken by the Board pursuant to this Section shall be effective on such date as approved by the Board. Amendment to the Bylaws accordingly shall occur during the next scheduled amendment process.

### **SECTION 3 REQUIREMENT FOR AFFILIATION WITH DEPARTMENTS AND SERVICES**

Each Member of the Medical Staff shall be assigned a primary affiliation with the Department which is most closely related to the residency training that was completed with consideration given, as appropriate, to and the nature of the individual's current practice.

Affiliated Health Care Professionals shall be assigned consistent with the Departmental assignment of their supervising/collaborating physician.

A Member may be granted clinical privileges in one or more of the other Departments and his/her exercise of clinical privileges within the jurisdiction of any Department is always subject the Bylaws, Medical Staff Rules and Regulations as well as to the rules and regulations of that department and the authority of the Department Chief.

#### **SECTION 4      CLINICAL DEPARTMENT / SERVICE FUNCTIONS**

##### Clinical Functions:

- a. establish, implement and monitor its Members' adherence to clinical standards, policies, procedures and practices relevant to the various clinical disciplines under its jurisdiction;
- b. provide an inter-specialty and inter-departmental forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its members' activities and the activities of other patient care and administrative services;
- c. develop consistency in the patient care data, standards, policies, procedures and practices within the department; and
- d. develop, with input as applicable from specialists and subspecialists, a delineation of clinical privileges that identifies the privileges and procedures as well as medical conditions that fall within the scope of the Department and associated criteria that include the required education, training and/or experience in order for Members to be considered qualified for these privileges. Recommends the privilege delineation and any changes to the Credentials Committee, MEC, and Board for approval. Periodically reviews for accuracy and updating to reflect changes in technology and practice.
- e. develop measures and indicators for use in Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) and recommends these to the Credentials Committee, MEC and Board for approval. Periodically reviews for updating to reflect changes in technology and practice.

##### Administrative Functions:

- a. Provide a forum for its Members to contribute their professional views and insights to the formulation of the Departmental, Medical Staff and Hospital policies and plans;
- b. communicate, through its Chair, formulated policies and plans back to its Members for implementation;
- c. coordinate, through its Chair, the professional services of its Members with those of other Departments and with the Hospital and Medical Staff Administration Department ; and
- d. make recommendations, through its Chair, to the MEC, the Chief Medical Officer, and others, as appropriate, concerning the short and long term allocation and acquisition of resources to and provision of services by the Hospital and the Department.

##### Quality Review/Utilization Management Functions:

- a. review quality and performance, risk management and utilization data and findings pertinent to Department Members, and make recommendations or take action as appropriate;
- b. review mortality and morbidity reports and special studies of input, processes and outcomes of care, perform specified monitoring activities, and otherwise participate as required in the quality review, risk management and utilization program; and
- c. report all findings of studies and other activities performed under paragraphs (a) and (b) immediately above to the Professional Practice Evaluation Committee .

### Collegial and Educational Functions:

Each department/service shall serve as the most immediate peer group for:

- a. providing clinical support among and between peers;
- b. teaching, continuing education and sharing new knowledge relevant to the practice of Department members; and
- c. providing consultative advice in its area to other Medical Staff Members.

## **SECTION 5 CLINICAL DEPARTMENTS AND SERVICE CHIEFS**

### Voluntary vs. Contract Department Chiefs

For purposes of these Bylaws, a Department Chief serving on a voluntary basis is referred to as a "voluntary Department Chief," and one serving as such by exclusive service contract with the Hospital is referred to as a "Contract Department Chief". The Emergency Department, Radiology, and Pathology and Clinical Laboratory Department will be the only Departments led by contract physicians.

### Qualifications:

The qualifications listed below are required in order to be eligible to serve as a Department or Service Chief:

- a. current Member of the Active staff and of the relevant Department; and
- b. certified by an appropriate specialty board as outlined in ARTICLE III, Section 5 or has demonstrated evidence of comparable competence;
- c. have demonstrated executive and administrative abilities through experience and prior participation in Medical Staff activities; and
- d. have demonstrated significant interest in and support of the Medical Staff and Hospital by virtue of tenure and level of clinical activity.
- e. agree to, if selected, willingly and faithfully discharge duties and functions and exercise the authority of the position and work with the Medical Staff Officers and other Department Chiefs and with the Chief Medical Officer, Chief Executive Officer, and Board and its committees.

### Election / Appointment:

- a. A voluntary Department Chief is elected by majority vote by secret ballot of those Members of the Department who are eligible and qualified to vote and who are present at the regular final Department meeting in any year in which the Department chief is to be elected. Department Chief appointments are subject to the approval of the Board. Nominations may be made and seconded at the meeting by any Member of the Active staff of the Department , provided that evidence of the qualifications of the nominee are prepared to be presented at the time of the meeting and that the nominee accepts such nomination.
- b. If the Emergency Department, Radiology, and Pathology and Clinical Laboratory Department are led by a contract Chief, that Chief is selected by the Board or its designee after seeking and considering the advice of appropriate representatives of the Medical Staff, the Chief Medical Officer and of the Chief Executive Officer.

### Term and Eligibility for Re-Election / Re-Appointment

- a. The usual term of office of a voluntary Department Chief is two (2) years. Successive terms may follow but generally for no more than two (2) consecutive terms.

Voluntary Chiefs assume office on the first day of the Medical Staff year following their election, except that a voluntary Chief elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each voluntary Chief serves until the end of his/her term and until a successor is elected, unless he/she sooner resigned or is removed from office.

- b. The term of office of a contract Department Chief of Emergency Medicine, Radiology and Pathology and Clinical Laboratory Departments is as specified in his/her contract or employment arrangement with the Hospital.

### Resignation of Chiefs

- a. A voluntary Department Chief may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time as specified in the communication.
- b. Resignation of a contract Chief is governed by the terms of the contract or other arrangement with the Hospital. If the contract does not address the issue, a contract Chief may resign by giving written notice to the Chief Medical Officer, Chief Executive Officer and the MEC. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any time specified in it.

### Removal of Department Chiefs

- a. Removal of a voluntary Chief may occur by a two-thirds majority vote of the Members of the Active Medical Staff of the applicable Department/service subject to ratification by the MEC. The Chief who is the subject of the removal shall be given ten (10) days prior written notice of a special or regular meeting of the MEC at which time the vote is to be taken and shall be afforded the opportunity to address the MEC on his/her behalf thereafter.
- b. Removal of a contract Chief of the Emergency Department, Radiology or Pathology and Clinical Laboratory Department is governed by the terms of the contract and by the provisions of these Bylaws, as applicable. The MEC may undertake a review of the performance of a contract Chief, transmitting a written report of its findings, conclusions and recommendations to the Board. If the Board disagrees with or is going to make a decision (including taking no action) contrary to the MEC's recommendation, the matter will be submitted to the Professional Affairs Committee (See ARTICLE XVIII, Part V, Section 3) for review and recommendation before the Board makes a final decision.
- c. Grounds for Removal: Permissible reasons for removal of a voluntary Chief are consistent with those described in ARTICLE X, Section 7 having to do with removal of a Medical Staff officer. Bases of removal of a contract Chief are as specified in the contract or other arrangements with the Hospital.

### Vacancies

A vacancy in a voluntary Department Chief position is filled by secret ballot vote at the next meeting of the Department.

**SECTION 6      RESPONSIBILITY, AUTHORITY, REPORTING OBLIGATIONS AND DUTIES OF DEPARTMENT / SERVICE CHIEFS**

Responsibility and Authority

A Department/Service Chief has the responsibility and authority to act accordingly to carry out the functions and responsibilities of the Department outlined in Section 4 above and as delegated to the Department by the Board, the MEC, and as stipulated in these Bylaws, the Medical Staff Rules and Regulations or Hospital and Medical Staff policies. Each Department Chief shall designate a qualified individual in his/her Department who can temporarily assume all responsibility and authority of the Chair in the event of his/her temporary absence or inability to execute his responsibilities.

Reporting Obligations:

Each Department / Service Chief shall report:

- a. On the activities of the Department, as requested, to special or regularly scheduled meetings of the MEC and Medical Staff ;
- b. Whenever necessary or requested to the President regarding matters involving coordination and monitoring of clinical services to maintain quality or to assure patient safety;
- c. To the President and the Professional Practice Evaluation Committee (PPEC) on action taken in response to a suggestion, recommendation or finding based on the case / quality review, issue with risk management or utilization review involving a Member of the Department;
- d. To the MEC and the Chief Medical and Chief Executive Officer regarding issues relating to the allocation and acquisition of resources for the various departments, budgetary items and similar concerns.

Specific Duties:

- a. Execute the clinical, administrative, quality, utilization management and collegial/educational functions of the Department;
- b. Participate on a continuous basis in managing the department/service through cooperation and coordination with the nursing and other patient care services, hospital management, and the President on all matters affecting patient care;
- c. Participate in planning with respect to Department/Service personnel, equipment, facilities, services and budget;
- d. Communicate and implement actions taken by the MEC, the Board, and other relevant authorities relative to the Department / Service;
- e. Serve on, and provide guidance to, the MEC, regarding policies of the Hospital related to the Department/Service and make specific recommendations and suggestions regarding the Department/Service to the MEC, hospital management, and the Board;
- f. Assist in developing, implementing and supervising relevant Medical Staff components of quality review, risk management and utilization management program as required in cooperation with President, the MEC and relevant Medical Staff committees;
- g. Monitor the performance and behavior of Department/Service Members through the Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation processes;
- h. Make recommendations to the Credentials Committee for appointment, reappointment and privileges for Members of the Department/Service based upon the requirements set forth in

ARTICLES III and VI and an evaluation of each applicant's competency. Such evaluation shall include consideration of all relevant information regarding the individual's clinical and professional performance in the Hospital and, to the extent applicable, based on external references including, but not limited to:

- patterns of care and utilization as demonstrated in the findings of professional practice evaluation;
- participation in relevant continuing education activities;
- level/amount of clinical activity at the Hospital;
- professionalism and cooperativeness in working with other Members and hospital staff and
- satisfactory health status.

With respect to reappointment, consideration in terms of eligibility and to which category the individual will be recommended will be given to:

- participation in Medical Staff, Department and Committee meetings;
- participation in on-call coverage arrangements;
- timely and accurate completion and preparation of medical records;
- compliance with Bylaws, Rules and Regulations and Hospital and Medical Staff Policies and procedures;
- any other pertinent information that may be relevant to the staff member's status and privileges including the Member's activities at other hospitals and his/her medical practice outside the Hospital.

- i. Maintain continuing review of patient care and the professional performance of Members of the Department/Service and present written reports, as appropriate, requested or required, to relevant Medical Staff committees concerning patterns or situations affecting patient care, and to the Credentials Committee or MEC when appropriate or required;
- j. Review data/information forwarded from the various Medical Staff committees charged with professional practice evaluation, risk management, or utilization management activities, respond to requests from and recommendations by said committees and make recommendations or take action as appropriate;
- k. Enforce the Corporate and Medical Staff Bylaws, Medical Staff Rules and Regulations and related, policies, and procedures, within the Department/Service, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary;
- l. Unless otherwise provided in the Medical Staff Bylaws, assign individual Department/Service members and/or appoint Department/Service committees as necessary to perform the functions of the Department/Service and designate a chair of each committee created;
- m. Preside over and prepare the agenda for all department meetings; and
- n. Perform such other duties and exercise such authority commensurate with the position as are set forth in the Medical Staff Bylaws, Medical Staff Rules and Regulations or in other Hospital or Medical Staff policies, and, if applicable, in a contract with the Hospital, and, as may from time to time be reasonably requested by the President, MEC, or Board.

## **ARTICLE XII: MEDICAL STAFF COMMITTEES**

### **SECTION 1 COMMITTEES OF THE MEDICAL STAFF**

The required Committees of the Medical Staff are as specified and described below.

They shall function as indicated in these Bylaws through assignment to the Medical Staff as a whole, to Departments, to Medical Staff committees, to Medical Staff Officers or to other individual Medical Staff Members. They may also function via interdisciplinary Hospital committees which include participation of Medical Staff Members.

### **SECTION 2 MEDICAL STAFF COMMITTEES**

There is a Medical Executive Committee (MEC) and such other standing and special Committees of the Medical Staff, a Department or other clinical unit, as are necessary and desirable to perform any of the functions listed among the responsibilities of the Committees listed below or elsewhere in these Bylaws or Medical Staff policies.

The composition, function, reporting and meeting requirements are outlined below.

The composition, functions, reporting and meeting requirements of special committees that are or may be required under any section of these Bylaws are as specified in the relevant section.

Any committee, regardless of whether it is Medical Staff-wide, Department/other clinical unit based, standing or special, that is carrying out all or any portion of a function or activity required by these Bylaws or any of the related manuals is deemed a duly appointed and authorized committee of the Medical Staff.

### **SECTION 3 REPRESENTATION ON HOSPITAL COMMITTEES AND PARTICIPATION IN CERTAIN HOSPITAL DELIBERATIONS**

The Medical Staff, through its Officers and Department Chiefs or their respective designees, will be represented and participate in any Hospital deliberations affecting the discharge of Medical Staff responsibilities.

### **SECTION 4 EX OFFICIO MEMBERS**

The Medical Staff President, Chief Medical Officer and the Chief Executive Officer, or their respective designees, are considered ex officio members of all standing and special committees of the Medical Staff, and with or without vote as provided in the provision or resolution creating the committee.

### **SECTION 5 ACTION THROUGH SUBCOMMITTEES**

Any standing committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose, reporting such action to the MEC in writing. Any such subcommittee may include individuals in addition to or other than members of the standing committee. Such additional members are appointed by the committee chair after consultation with the Medical Staff President in the case of Medical Staff Members, and with the approval of the Chief Medical Officer and Chief Executive Officer or his/her designee when administrative staff appointments are to be made.



## **SECTION 6 COMPOSITION**

A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee. Any other committees that may be established to perform one or more of the Medical Staff functions required by these Bylaws will be composed of Members of the Active Staffs and may include members of the Consulting staff. Where appropriate, Affiliated Health Care Professionals and representation from management, nursing service, medical records, and such other hospital departments as are appropriate to the functions to be discharged by the committee may also be included. Each designated member of a committee participates with vote, unless the statement of the committee composition designates the position as non-voting.

## **SECTION 7 APPOINTMENT OF MEMBERS AND CHAIR**

Except as otherwise expressly provided, the Medical Staff President appoints the members and chair of any Medical Staff committee formed to accomplish Medical Staff functions. Each committee chair must be a Member of the Active Medical Staff. Non-medical staff members of committees, are subject to the approval of the President or his/her designee.

When necessary to accomplish a function or task assigned to a committee, the committee chair may call on outside consultants or special advisors from clinical specialties or administrative or patient care departments with expertise in the subject matter involved, after consultation with the Chief Medical Officer or his/her designee when hospital administrative or patient care departments or outside consultants are involved. Each committee chair appoints a vice-chair to chair any meeting in his/her absence. Each committee chair or other authorized individual serving as chair has the right to participate in discussion of and to vote on issues presented to the committee.

## **SECTION 8 TERM, PRIOR REMOVAL AND VACANCIES**

Each committee member, except one serving ex officio, serves a two-year term, unless the member resigns from the Medical Staff or is removed from the committee or the Medical Staff. A Medical Staff member serving on a committee may be removed from the committee for failure to satisfy any committee attendance requirements specified in these Bylaws or by action of the MEC or Board as appropriate.

Any ex officio member of a staff committee ceases to be such if he ceases to hold a designated position which is the basis of ex officio membership. A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which original appointment is made.

## **SECTION 9 MEDICAL EXECUTIVE COMMITTEE (MEC)**

### **Composition**

The MEC includes physicians and other individuals as noted below.

The Medical Staff President shall serve as Chair of the MEC along with the following all of whom shall have voting rights:

- Medical Staff President,
- Medical Staff President Elect
- Medical Staff Secretary-Treasurer
- Immediate Past President
- Chief of Surgery
- Chief of Medicine
- Chief of Emergency Services

- Chief of Anesthesia
- Chief of Radiology
- Chief of Pathology
- Chief of Psychiatry
- Chief, Hospitalist
- Affiliated Health Care Professional representative

Membership shall also include:

- two (2) members-at-large with voting rights, who will be nominated from the floor and elected by majority vote at the annual meeting of the Medical Staff

The following shall serve without voting rights:

- Chief Executive Officer
- Chair of the Board (or his/her designee)
- Chief Medical Officer
- VP for Patient Care Services

### **Duties and Authority**

The MEC acts on behalf of the Medical Staff and has the duties and authority as noted below:

- a. supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical unit; act on all matters of Medical Staff business, except for election of Officers,
- b. removal of Officers;
- c. adoption and amendment of Medical Staff Bylaws, Rules and Regulations and Medical Staff policies;
- d. receive, coordinate and act upon, as necessary, the written reports and recommendations of the Departments and the standing and special committees directly responsible to it and to hear oral reports from time to time as required or requested;
- e. coordinate, or oversee coordination of, the activities of and policies adopted by the Medical Staff, Departments, other clinical units and committees; implement the approved policies of the Medical Staff, or monitor that such policies are implemented by the Departments and other clinical units and committees;
- f. study and report to the Medical Staff regarding proposals for changes to the Bylaws, Medical Staff Rules and Regulations or Policies;
- g. inform the Medical Staff about accreditation programs and the accreditation status of the Hospital;
- h. review and approve the appointment of chairs and members of standing committees, except as otherwise provided;
- i. receives Credentials Committee reports and makes recommendations to the Board regarding Medical Staff appointments, reappointments category and department assignments, clinical privileges, and disciplinary actions;
- j. take reasonable steps to insure that Medical Staff Members exhibit professional and ethical conduct and competent clinical performance;

- k. initiate investigations and pursue disciplinary action of Medical Staff Members when appropriate based on Bylaw requirements;
- l. account to the Board by written report for the quality of medical care provided to patients in the Hospital, including a summary of specific findings, action and follow-up as appropriate; and
- m. make recommendations to the Chief Medical Officer and Chief Executive Officer on medico-administrative, Hospital management and planning matters.

### **Meetings and Reporting**

The MEC shall meet at least once per month. Meeting minutes are made available to Members of the Medical Staff via the Medical Staff Administration Department. Department Chiefs are expected to communicate relevant information, policies and decisions from the MEC to Members of their respective departments accordingly.

Other reporting obligations of the MEC are as stated in the various sections of these Bylaws. Copies of the minutes and reports of the MEC are forwarded to the Chief Medical Officer, Chief Executive Officer, and, as appropriate, to the Board.

## **SECTION 10 COMMITTEES OF THE MEC**

The following will be standing committees responsible to the MEC:

- a. Bylaws Committee
- b. Credentials Committee
- c. Ethics Committee
- d. Medical Education Committee
- e. Critical Care (ICU-CCU) Committee
- f. Pharmacy and Therapeutics Committee,
- g. Professional Practice Evaluation Committee (PPEC)
- h. Cancer Committee
- i. Medical Staff Health Committee
- j. Infection Prevention and Control Committee

### **BYLAWS COMMITTEE**

The responsibilities of the Bylaws Committee are as follows:

- Conduct a periodic review and revision of the Medical Staff Bylaws and Rules and Regulations
- Investigating and providing recommendations on special projects and activities of concern to the staff as are referred by the MEC
- Submit written recommendations to the MEC and medical staff regarding changes in these documents.

The Bylaws Committee composition includes the following:

- a. President Elect, who shall serve as chair with vote;

- b. a minimum of four additional Medical Staff Members;
- c. Medical Staff President, with vote;
- d. Chief Medical Officer, without vote.

## **CREDENTIALS COMMITTEE**

The responsibilities of the Credentials Committee are as follows:

- Receives the recommendation of the relevant Department Chief and evaluates the training, education, experience and competence of applicants for initial appointment, reappointment, or privileges requested between reappointment cycles and makes a recommendation on each to the MEC accordingly;
- Makes recommendations to the MEC regarding the conclusion or extension of the Focused Professional Practice Evaluation (FPPE) period for new applicants based upon information and recommendation from the relevant Department Chief;
- Integrates quality review, risk management and utilization management findings, membership and other relevant information into the credentialing and privileging evaluation process;
- Evaluates the qualifications of Medical Staff Members who seek privileges to perform new procedures and makes recommendation to the MEC.
- Meets on a monthly basis and reports monthly to the MEC.

The Credentials Committee may opt to appoint a Sub-Committee to act on its behalf with respect to clean applicants for appointment that are eligible for temporary privileges consistent with these Bylaws and relevant Medical Staff Policies.

The Credentials Committee composition includes the following:

- a. Immediate Past President, who shall serve as Chair with vote
- b. Medical staff president, with vote;
- c. Chief executive officer or designee, without vote; and
- d. Chief Medical Officer, without vote, and
- e. a minimum of four additional Medical Staff Members chosen by the President/Immediate Past President
- f. representative from Medical Staff Administration Department without vote
- g. a member of the Board, without vote

With approval from the Medical Executive Committee, some or all of the responsibilities of the Credentials Committee may be assumed by a Centralized Credentials Committee that includes representatives from each of the participating YNHHS Affiliated Hospital Medical Staffs. Representatives from the Westerly Hospital Medical Staff shall include the Chief Medical Officer or individuals selected by the Chief Medical Officer.

Any recommendations made by the Centralized Credentials Committee shall be forwarded directly to the Medical Executive Committee for action.

## **ETHICS COMMITTEE**

The responsibilities of the Ethics Committee are as follows:

- establishes and reviews policies and guidelines that address ethical aspects of Hospital practice
- provides consultation on individual cases where ethical issues have been raised
- develops educational and other resources regarding medical ethical issues and makes them available to Medical Staff and hospital staff
- Meets on at least a quarterly basis and provides an annual written report to the MEC

The Ethics Committee composition includes the following:

- a. Chair, with vote, as appointed by the MEC
- b. representatives from the Active Medical Staff
- c. representative(s) from nursing
- d. representative from religious ministries
- e. representative from Legal & Risk Services
- f. and other members deemed appropriate based upon unique expertise or background in ethics from among or external to the Hospital staff

### **MEDICAL EDUCATION COMMITTEE**

The responsibilities of the Medical Education Committee are as follows:

- Develops and follows the mission statement adopted by the medical education committee in compliance with the ACGME.
- Oversees the operation of the Medical Staff library.
- May meet quarterly or on an as needed basis and reports on its activities to the MEC

The Medical Education Committee composition includes the following:

- a. a member of the Medical Staff appointed as chair and with vote;
- b. four to six Members of the Medical Staff representing the Departments, all with vote;
- c. librarian, without vote;
- d. Medical Staff President or designee, with vote;
- e. Chief Medical Officer or designee, without vote

### **CRITICAL CARE COMMITTEE**

The responsibilities of the Critical Care (ICU-CCU) Committee are as follows:

- formulates and periodically reviews operational policies, protocols and treatment modalities, and other rules governing conduct and procedures in the ICU-CCU area;
- develops screening criteria to review the quality and appropriateness of care provided in the unit and reviews findings and makes recommendations for corrective action and/or education programs, as indicated;
- reviews all deaths that occur in the ICU-CCU;
- makes recommendations relating to equipment, drugs, supplies and other items to be available in the ICU-CCU; and
- meets at least semi-annually and reports to the MEC

The Critical Care Committee composition includes the following:

- a. a chair, with vote;
- b. nursing representative from the ICU-CCU, without vote;
- c. four to six Medical Staff Members including at least one (1) representative each from anesthesia, surgery and internal medicine, with vote;
- d. director of respiratory care or designee, without vote;
- e. Medical Staff President or designee, with vote;
- f. director of nursing or designee, without vote;
- g. Chief Medical Officer, without vote

#### **PHARMACY AND THERAPEUTICS COMMITTEE**

The responsibilities of the Pharmacy and Therapeutics Committee are as follows:

- Assists in the formation and review of policies regarding drug evaluation, appraisal, selection, procurement, storage, distribution, use, safety relating to drugs in the Hospital;
- Makes recommendations concerning drugs to be stocked on the nursing units;
- Develops a mechanism to identify and review reports on all untoward drug reactions;
- Evaluates clinical data concerning new drugs or preparations requested for use in the Hospital;
- Reviews and develops nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; and
- Meets at least quarterly and reports to the MEC

The Pharmacy and Therapeutics Committee composition includes the following:

- a. a chair, with vote;
- b. up to six additional Members of the Active staff representative of the major clinical departments, with vote;
- c. Pharmacy Director, with vote
- d. other representatives from pharmacy service, without vote;
- e. representative from nursing service, without vote;
- f. representative from dietary service, without vote;
- g. quality assurance nurse, without vote;
- h. Medical Staff President or designee, without vote; and
- i. Chief Medical Officer or designee, without vote

#### **PROFESSIONAL PRACTICE EVALUATION COMMITTEE (PPEC)**

The Professional Practice Evaluation Committee (PPEC) serves as the medical peer review committee for the Medical Staff and, as such, is the Medical Staff body responsible for monitoring and evaluating Medical Staff clinical quality, and matters related to unprofessional behavior. The work product of the PPEC will be considered as confidential peer review to the fullest extent allowed under the applicable RI statute.

In conducting its business, the Committee may, among other information, include consideration of the following:

- Pre-screened information submitted via the safety event reporting system

- surgical case review
- blood usage and transfusion reactions
- infections
- medical records review for completeness and clinical pertinence
- antibiotic and other drug reviews
- morbidity/mortality
- pharmacy and therapeutics
- clinical risk management indicators to review patterns of unexpected care events including malpractice experience and identify areas for change to reduce liability
- utilization review to maintain appropriate, effective and efficient utilization of the diagnostic and therapeutic resources of the Hospital, and review of medical decisions which may have ethical implications
- Provides oversight to the Ongoing Professional Practice Evaluation (OPPE) process and “for cause” Focused Professional Practice Evaluation (FPPE)
- Meets at least four (4) times per year or more frequently as needed and reports to the MEC

The PPEC composition includes the following:

- a. President who shall serve as chair, with vote;
- b. three (3) to four (4) members of the Active Medical with vote;
- c. ad hoc representation from appropriate specialty Department areas to assist with case review as necessary; without vote
- d. risk manager and a representative from the Medical Staff Administration Department as support staff, without vote,
- e. chief medical officer, without vote

## **CANCER COMMITTEE**

The responsibilities of the Cancer Committee shall be as follows:

- develop and maintain a cancer program that will benefit patients with cancer;
- plan, initiate and assess all cancer related activities in the Hospital
- organize, publicize, conduct cancer conferences that are multidisciplinary Hospital-wide and patient oriented
- ensure that consultative and rehabilitative services are available to all patients
- plan and complete a minimum of two patient care evaluation studies annually
- oversee the cancer registry
- publish and distribute an annual report
- meet at least quarterly

The Cancer Committee composition includes the following:

- a. a chair, with vote;
- b. physician members representing, but not limited to, surgery, medical oncology, diagnostic radiology, radiation oncology, pathology, internal medicine and/or family practice, obstetrics/gynecology, with vote;
- c. administrative support staff to include: cancer registrar, quality management, nursing and social services, with vote.

## **MEDICAL STAFF HEALTH COMMITTEE**

The responsibilities of the Medical Staff Health Committee are as follows:

- providing education to Hospital administration and Medical Staff regarding issues related to medical staff health;
- provide assistance and rehabilitation to support Medical Staff Members with physical or mental illness including substance abuse in retaining or regaining optimal functioning;
- evaluate Medical Staff Members when concerns are raised related to physical or mental conditions that might affect the individual's ability to exercise all or part of his/her clinical privileges with reasonable skill and safety as identified by other Members or Hospital staff, following illness or accident, or leave of absence as applicable;
- facilitate confidential diagnosis, treatment and rehabilitation as appropriate including referral to the State of RI Practitioner Health Program as applicable; and
- make referrals as necessary to the Credentials Committee

The composition of the Medical Staff Health Committee includes:

- a. President who shall serve as chair; with vote and
- b. three (3) additional experienced Members of the Active staff members to be representative of the major clinical departments, with vote;

The Medical Staff Health Committee will be convened on an ad hoc basis as needed.

## **INFECTION PREVENTION & CONTROL COMMITTEE**

The responsibilities of the Infection Prevention & Control Committee are as follows:

- to maintain an Infectious Disease Program that will benefit all patients
- planning, initiating and assessing all infection control/prevention related activities in the Hospital
- provide performance improvement reports on a quarterly basis to the MEC and Patient Safety and Clinical Quality Committee of the Board
- meets at least every other month

The composition of the Infection Prevention & Control Committee shall include:

- a. a chair of any specialty, with vote;
- b. if there is a Member of the Medical Staff who specializes in Infectious Disease that individual should be included, with vote;
- c. representatives of the Active Medical Staff , with vote;
- d. administrative support staff to include: quality management and nursing without vote, and wound care without vote.

## **SECTION 11 MEETING PROCEDURES**

### **NOTICE OF MEETINGS**

Notice regarding any regular general Medical Staff meeting, or of any regular committee or Department meeting shall be provided to members within a reasonable period of time.



Notice of any special meeting of the Medical Staff, a Department or a committee must be given orally or in writing at least seventy two (72) hours prior to the meeting. The business of the meeting shall be focused upon the specific topic about which the meeting was called.

## **QUORUM**

Those members present constitute a quorum.

## **ORDER OF BUSINESS AT REGULAR MEETINGS OF THE MEDICAL STAFF**

The order of business is determined by the President of the Medical Staff.

The agenda shall include, at minimum, the following items:

- a. Acceptance of the minutes of the last regular Medical Staff and any special meetings held since the last regular meeting.
- b. Administrative reports from the President, Department Chiefs, Chief Medical Officer, and Chief Executive Officer.
- c. The election of Medical Staff officers and of representatives to Medical Staff and Hospital committees, when required by the Medical Staff Bylaws.
- d. Reports by Medical Staff Officers, Department Chiefs and committees as may be requested.
- e. New Business

## **MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members present and voting at a Medical Staff meeting at which a quorum is present is the action of the group.

## **MINUTES**

Minutes of all meetings shall be prepared and include a record of attendance and the vote taken on each matter. Copies of minutes must be approved by the attendees, and forwarded to the MEC. Minutes shall be made available, in the Medical Staff Administration Department. A permanent file of the minutes of each meeting shall be maintained.

## **PROCEDURAL RULES**

Meetings of the Medical Staff, Department/Service and committees, will be conducted according to the then current edition of Roberts' Rules of Order. In the event of conflict between those Rules and any provision of the Medical Staff Bylaws, the latter shall supersede.

## **ARTICLE XIII: MEDICAL STAFF MEETINGS**

### **SECTION 1 MEDICAL STAFF MEETINGS**

#### **REGULAR MEETINGS**

A regular annual Medical Staff meeting will be held within ninety (90) days of the end of the Medical Staff year. The Medical Staff will set the number of meetings for the ensuing year at the time of the annual meeting.

#### **SPECIAL MEETINGS**

A special meeting of the Medical Staff may be called by the President on his/her own motion, and must be called by the President at the written request of the Board, the MEC or one fourth of the Members of the Active Medical Staff.

#### **EXECUTIVE SESSION**

The Medical Staff, any committee or Department/Service may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group may be present during said session unless the presiding officer thereof invites, with the approval of a majority of the group, other individuals to attend. Accurate and complete minutes must be kept of any executive session.

### **SECTION 2 DEPARTMENT/SERVICE AND DEPARTMENT/SERVICE BASED COMMITTEE MEETINGS**

#### **REGULAR MEETINGS**

Clinical Departments/Services and Department/Service based committees may, by resolution, provide the time for holding their regular meetings and no notice other than such resolution is then required. Department meetings may be held as frequently as necessary depending upon business requirements and/or the discretion of the Department/Service Chief but no less than twice per year. The frequency of committee meetings is as required by these Bylaws for each committee.

#### **SPECIAL MEETINGS**

A special meeting of any Department/Service or Department/Service based committee may be called by the Chief thereof, and must be called by the Chief at the written request of the Board, the MEC, the Medical Staff President, or one third, but not less than two (2), of the group's current members.

### **SECTION 3 ATTENDANCE REQUIREMENTS**

#### **GENERALLY**

In addition to satisfying the Special Appearance Requirement as noted below, each Member of the Active Staff category is expected to attend the annual Medical Staff meeting, meetings of his/her respective Department, and meetings of any committees on which he or she serves. The number of absences will be evaluated as part of each Member's reappointment or more frequently if circumstances so warrant.

#### **MEETING PROCEDURES**

Notice, quorum, minutes and agenda requirements for meetings are set forth in Section 11 of ARTICLE XII.

## **ARTICLE XIV: CONFIDENTIALITY, IMMUNITY AND RELEASES**

### **SECTION 1 SPECIAL DEFINITIONS**

For purposes of this Article only, the following definitions shall apply:

- a. Information means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in "Activities and Information Covered" below
- b. Malice means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
- c. Representative means: the Board of the Hospital and any director or committee thereof; the Chief Executive Officer or his/her designees; registered nurses and other employees of the Hospital; the Medical Staff organization and any Member, Officer, clinical unit or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.
- d. Third Parties mean any individual or organization providing information to any representative.

### **SECTION 2 CONFIDENTIALITY OF INFORMATION**

Information submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, monitoring or improving the quality of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care shall, to the fullest extent permitted by law, be confidential.

Such information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise specifically required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record.

It is expressly acknowledged by each applicant or Member of the Medical Staff that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff membership and clinical privileges or specified services.

### **SECTION 3 IMMUNITY FROM LIABILITY**

Immunity from liability for representatives acting in good faith relative to the activities involved in initial and reappointment of applicants to and Members of the Medical Staff is outlined in ARTICLE VI, Section 3.

### **SECTION 4 ACTIVITIES AND INFORMATION COVERED**

#### **ACTIVITIES**

The confidentiality and immunity provided by this Article applies to all information or disclosures performed or made in connection with this or any other health care facility or organization's activities concerning, but not limited to:

- a. applications for appointments, clinical privileges or specified services
- b. periodic reappraisals for reappointment, clinical privileges or specified services
- c. professional review activity and actions
- d. hearings and appellate reviews
- e. quality review program activities
- f. utilization review and management activities.
- g. claims reviews
- h. profiles and profile analysis
- i. risk management activities
- j. other Hospital, committee, Department, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

## **INFORMATION**

The information referred to in this Article may relate to an individual's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, fitness for duty, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency or appropriateness of patient care provided in the Hospital.

## **SECTION 5      ACKNOWLEDGEMENT, AGREEMENT AND RELEASES**

Each applicant and Medical Staff Member shall, at the time of initial appointment and reappointment and at other times as applicable and requested, sign general and specific releases in accordance with the tenor and import of this Article and further specified in ARTICLE VI, Sections 2 and 3, subject to such requirements, as may be applicable under relevant Rhode Island and federal law.

Failure to execute such releases as requested shall result in an application for initial appointment, reappointment or clinical privileges being deemed incomplete and to have been voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases in connection with conclusion of the FPPE period shall be deemed a voluntary resignation of staff membership or particular clinical privileges as appropriate to the context.

## **SECTION 6      CUMULATIVE EFFECT**

Provisions in these Bylaws and in application forms relating to authorization, confidentiality of information and immunities from liability are in addition to other protections provided by relevant Rhode Island and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

## **ARTICLE XV: GENERAL PROVISIONS**

### **SECTION 1 MEDICAL STAFF RULES AND REGULATIONS**

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board via the process identified in ARTICLE XVI.

These rules shall relate to the proper conduct of the Members of the Medical Staff and their organizational activities as well as embody the level of practice that is to be required in the Hospital. The Rules and Regulations shall be considered a part of these Bylaws.

### **SECTION 2 DEPARTMENT RULES**

Each Department will formulate written rules for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with these Bylaws, Medical Staff Rules and Regulations and Medical Staff and Hospital policies. Department rules must be approved by the MEC, the Medical Staff via its next staff meeting, and the Board.

## **ARTICLE XVI: ADOPTION AND AMENDMENT**

### **MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

The Board holds the Medical Staff responsible for the development, adoption, and periodic review of Medical Staff Bylaws, all of which must be consistent with Hospital policies and applicable laws and other requirements.

The Medical Staff Bylaws (and, by incorporation, Rules and Regulations) shall be reviewed periodically by the Bylaws Committee, and may be reviewed more frequently when deemed necessary by the Medical Staff, the MEC or the Hospital.

### **SECTION 1 PROPOSING AMENDMENTS**

Proposed amendments to the Medical Staff Bylaws and Rules & Regulations are referred to the MEC or Bylaws Committee of the MEC.

Suggestions for changes may originate from a routine review and updating initiated by, but not limited to, the Bylaws Committee, MEC, Medical Staff Officers, Department Chiefs, the Chief Medical Officer or the Board.

Additionally, if 60% of the Members of the Medical Staff with voting rights sign a petition to do so, they may propose amendments to the Bylaws or Rules & Regulations by submitting their proposals in writing to the Bylaws Committee of the Medical Executive Committee. A representative(s) from the petitioning group will be invited to participate in the Bylaws Committee.

### **SECTION 2 MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION**

All proposed amendments, regardless of source, shall ultimately be presented to the MEC. Proposals for Bylaws and Rules and Regulations changes or amendments shall be distributed to members of the MEC at least seven (7) days in advance of the meeting at which they will be considered.

A simple majority of those present and voting at the MEC may recommend approval, disapproval, approve recommendations with modifications or refer proposed amendments in whole or in part to the Bylaws Committee for initial review or re-evaluation.

### **SECTION 3 VOTING BY THE MEDICAL STAFF**

All amendments approved by the MEC shall be submitted to the voting members of the Medical Staff. Voting members shall be allowed a minimum of fourteen (14) calendar days to consider the proposed amendments. Notifications shall be sent electronically.

The President and President Elect (Bylaws Chair) shall make a determination as to whether the proposed changes are substantive enough to warrant discussion at a Medical Staff Meeting and, if so, the notification regarding the proposed changes shall include a date, time and location of the Medical Staff Meeting at which the amendments will be discussed.

In the event that 25% or more of voting members signify disagreement with any of the proposed amendments, either via expression at the Medical Staff Meeting or in discussion with an elected medical staff officer, these concerns will be transmitted to the Bylaws Committee of the MEC for review and consideration. One or more representative from the dissenting group will be invited to participate in the Bylaws Committee.

If fewer than 10% of voting members voice objection, the amendments shall be deemed recommended for approval and forwarded for action to the Board.

### **SECTION 4 BOARD ACTION**

Amendments approved by the MEC and the voting members of the Medical Staff shall be forwarded to the Board.

In the event that the Board modifies or disapproves any amendments proposed by the MEC and the voting members of the Medical Staff, such modifications shall be returned to the MEC which may accept or reject the modifications.

If the MEC accepts the modifications, they shall be submitted once again to the voting members of the Medical Staff as outlined in Section 3. above.

If the MEC rejects the modifications, the amendment and arguments against the modifications shall be resubmitted to the Board.

The Board and MEC shall make all efforts to resolve disagreement regarding Bylaw changes. In the event that resolution cannot be reached a conference shall convene among the Board officers, Medical Staff Officers and MEC Chair.

### **SECTION 5 APPROVAL REQUIREMENTS**

The Bylaws, which include the accompanying Rules and Regulations and, to the extent required by regulatory requirements, medical staff policies, may be changed or amended as described in Sections 1 through 4 above.

### **SECTION 6 EFFECTIVE DATE**

Amendments shall be considered effective as of the date approved by the Board.

**SECTION 7      NON SUBSTANTIVE EDITS**

Notwithstanding any of the above, the MEC is authorized to make non-substantive changes to the Bylaws, Rules & Regulations and medical staff policies relating to the organization of these documents including renumbering, grammar, spelling, typographical errors and similar technical revisions without approval of the voting members of the Medical Staff.

**SECTION 8      URGENT AMENDMENTS**

When there is a significant concern regarding compliance with federal, state or regulatory requirements, the MEC may recommend urgent amendments directly to the Board without consulting the Medical Staff. The Medical Staff is immediately notified and has the opportunity for retrospective review and comment on the amendments. If there is no conflict between the MEC and the Medical Staff regarding the amendment, the amendment stands. If the Medical Staff later objects to an amendment approved by this expedited process, the matter can be addressed through the conflict resolution process outlined in ARTICLE XVII.

**ARTICLE XVII: CONFLICT RESOLUTION**

The Medical Staff and the Board will make best efforts to address and resolve all conflicts in the best interest of patients, the Hospital and the Medical Staff.

When the MEC, the Medical Staff, or the Board considers acting in a manner contrary to a recommendation made by the MEC, the Medical Staff, or the Board, the Medical Staff Officers shall meet as soon as possible with the Board, or designated committee of the Board and Administration, to seek to resolve the conflict through informal discussions.

If these informal discussions fail to resolve conflict, the Medical Staff President, a majority of the voting members of the Medical Staff, the Chief Executive Officer of the Hospital, or the Chair of the Board may request initiation of a formal resolution process.

The formal conflict resolution process will begin with a meeting of a Joint Conference Committee within thirty (30) calendar days of the initiation of the formal process. The Joint Conference Committee shall be composed of the following:

- Medical Staff representatives including, at a minimum, the three (3) officers of the Medical Staff and three (3) other Medical Staff members as recommended by the Officers and elected by the Medical Staff
- Chief Medical Officer
- Chief Executive Officer
- Board Chair

If after sixty (60) days from the date of the initial request for the formal conflict resolution process, the Joint Conference Committee is unable to resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue which gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken in a shorter time period than allowed through this formal conflict resolution process due to an urgent issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take action that will remain in effect until the conflict resolution process is completed. This Article

XVII shall not be construed to constitute a waiver by any party or any remedies otherwise available under applicable law.

## **ARTICLE XVIII: FAIR HEARING PLAN**

Note: Fair Hearing Procedures for Members in the Affiliated Health Care Professional Staff Category can be found in ARTICLE V.

### **PART I: INITIATION OF HEARING**

#### **SECTION 1 TRIGGERING EVENTS / RECOMMENDATIONS OR ACTIONS**

The recommendations of the MEC or actions by the Board, as discussed in ARTICLE IX of the Medical Staff Bylaws, entitle the Practitioner (physician, dentist or podiatrist) applying for or exercising clinical privileges or providing other diagnostic or therapeutic services at the Hospital, to a hearing upon timely and proper request.

#### Exceptions to Hearing Rights

The actions or recommendations as outlined in ARTICLE VIII, Section 2:

- do not entitle a Member to a hearing.

#### **SECTION 2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION**

The Chief Medical Officer shall, within thirty (30) days of receiving written notice of an adverse action or recommendation, give the Practitioner written notice, return receipt requested, thereof. The notice shall:

- a. advise the Practitioner of the grounds of the proposed recommendation or action and of his or her right to a hearing upon timely and proper request pursuant to Section 3 below;
- b. specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section 3;
- c. state that failure to request a hearing within that time period and in the proper manner constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice;
- d. state that any higher authority required or permitted under this plan to act on the matter following a waiver pursuant to Section 4 is not bound by the adverse recommendation or action that the Practitioner has accepted by virtue of the waiver, but may take any action it deems warranted by the circumstances; and
- e. state that upon receipt of his hearing request, the Practitioner will be notified of the date, time and place of the hearing, and the grounds upon which the adverse recommendation or action is based.

#### **SECTION 3 REQUEST FOR A HEARING**

The Practitioner shall have thirty (30) days after receiving a notice under Section 2 to file a written request for a hearing. The request must be delivered to the Chief Medical Officer by written notice return receipt requested. If the Practitioner wishes to be represented by an attorney at the hearing, his or her request for a hearing must so state.



#### **SECTION 4 WAIVER BY FAILURE TO REQUEST A HEARING**

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 3 waives his or her right to any hearing or appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse action or recommendation triggering the Section 2 notice. The Chief Medical Officer shall as soon as reasonably practical send the Practitioner written notice of each action taken under any of the following Sections and shall notify the President of the Medical Staff of each such action. The effect of a waiver is as follows:

- a. **Effect of Waiver After Adverse Action by the Board:**  
A waiver shall constitute acceptance of the adverse action, which shall immediately become effective as the final decision of the Board.
- b. **Effect of Waiver after adverse recommendation by the MEC:**  
A waiver shall constitute acceptance of the MEC's adverse recommendation, which then shall become and remain effective immediately pending the decision of the Board. The Board shall consider such adverse recommendation as soon as practicable following the waiver. The Board is not bound by an adverse recommendation of the MEC, but may take any action it deems warranted by the circumstances, which may include referring the matter to the Professional Affairs Committee for its recommendations as set forth in PART V, Section 3, or taking action which may accord in all respects with the MEC's adverse recommendation, or be more or less severe, but in any event shall then become effective immediately as the final decision of the Board.
- c. **Additional Information obtained Following Waiver:**  
If the Practitioner has additional information which was not available or reasonably discoverable as of the date the right to a hearing was waived, and provided fewer than seven (7) days have elapsed since the date the right to a hearing was waived, the Practitioner is entitled to request a hearing in accordance with Section 3 to submit additional information.

The hearing shall be limited in scope to findings of fact surrounding the additional information and the findings, actions, and recommendations of the Board or the MEC made prior to the Practitioner's initial waiver. Said additional information shall not be considered unless the party making the initial adverse recommendation or action concludes that the information was not available or reasonably discoverable in time for presentation to or consideration by the party making the initial adverse recommendation or action.

Said additional information shall be submitted to, and the decision whether said additional information shall be considered shall be made by, the body other than that whose adverse recommendation or action has prompted the matter, e.g., if an adverse recommendation by the MEC has prompted the matter, then the Practitioner shall submit additional information to the Board, who shall decide whether the additional information shall be considered.

If the matter has been occasioned by an adverse action of the Board, and the MEC decides that the Board shall consider said additional information, the Board shall reconsider the matter in light of the additional information, and render its decision, which shall be the final decision of the Board.

If the matter has been occasioned by an adverse recommendation of the MEC, and the Board decides that the MEC shall consider said additional information, the matter shall be referred back to the MEC for reconsideration in light of the additional information. The MEC shall render a follow-up recommendation within thirty (30) days. The MEC's follow-up recommendation following consideration of said additional information shall become effective immediately pending the decision of the Board, whose decision will be effective immediately as its final decision.

## SECTION 5

### FAIR HEARING PREREQUISITES

a. Notice of Time and Place for Fair Hearing

Upon receiving a timely and proper request for hearing, the Chief Medical Officer shall deliver it to the President of the Medical Staff or the Chair of the Board, depending on whose recommendation or action prompted the hearing request. The President of the Medical Staff or Chair of the Board, as appropriate, shall then schedule a hearing before the Fair Hearing Committee and notify the Chief Medical Officer of that hearing date, immediately upon scheduling that hearing. The Chief Medical Officer shall, within fifteen (15) days of being informed of the hearing date, send the Practitioner notice, return receipt requested, of the time, place and date of the hearing.

The hearing date shall be set for neither less than thirty (30) nor more than sixty (60) days after the Chief Medical Officer received the hearing request. However, the hearing for a Practitioner who is under suspension then in effect must be held as soon as the arrangements may reasonably be made, but not later than fifteen (15) days after the Chief Medical Officer received the hearing request.

b. Statement of Issues and Events

The notice of hearing must contain a concise statement of the Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter(s) forming the basis for the adverse action(s) or recommendation(s) which is (are) the subject of the hearing.

c. Service on and Appointment of Fair Hearing Committee

1. Service on Fair Hearing Committee

The Fair Hearing Committee shall be composed either of Practitioners who are Members of the Medical Staff (including physicians employed by the Hospital and its affiliates) or other practitioners who are not competitors with the affected practitioner, or a combination of such persons. A Practitioner who is a Medical Staff Member or other person is not disqualified from serving on a Fair Hearing Committee merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be.

2. Appointment of Fair Hearing Committee Following Adverse Recommendation by Medical Staff

A hearing occasioned by an adverse MEC recommendation is conducted by a Fair Hearing Committee appointed by the President of the Medical Staff and composed of at least three (3) Practitioners who are Members of the Medical Staff (including physicians employed by the Hospital and its affiliates) or other practitioners who are not competitors with the affected Practitioner, none of whom has had prior involvement in the Practitioner's matter, and none of whom practices in the same specialty area as the Practitioner. However, a Practitioner who is a Member of the Medical Staff or other practitioner (including physicians employed by the hospital and its affiliates) is not disqualified from serving on a Fair Hearing Committee under this Subsection merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. The President of the Medical Staff shall designate one of the appointees as Chairperson of the Fair Hearing Committee.

3. Appointment of Fair Hearing Committee Following Adverse Action by the Board

A hearing occasioned by an adverse action of the Board is conducted by a Fair Hearing Committee appointed by the Chair of the Board and composed of three (3) Practitioners who are Members of the Medical Staff (including physicians employed by the Hospital and

its affiliates) or other practitioners who are not competitors with the affected Practitioner, provided that no such person has had prior involvement in the Practitioner's matter, and further provided that no such person practices in the same specialty area as the Practitioner. However, a Practitioner Member of the Medical Staff or other practitioner (including physicians employed by the Hospital and its affiliates) is not disqualified from serving on a Fair Hearing Committee under this Subsection merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. The Chair of the Board shall designate one of the appointees as Chair of the Fair Hearing Committee.

## **SECTION 6 LIST OF WITNESSES; PREHEARING MEMORANDA**

At least ten (10) days prior to the scheduled date for commencement of the hearing, each party shall give the other party by written notice a list of the names of the individuals who, as far as is then reasonably known, will give testimony or evidence in support of that party at the hearing. No outside expert witness (as opposed to a Fair Hearing Committee member with familiarity of the subject which the expert witness shall address) shall be permitted to give testimony or evidence in support of a party at the hearing unless the expert witness shall agree to cross-examination. Such list shall be amended as soon as possible when additional witnesses are identified. The Fair Hearing Committee may permit a witness who has not been listed in accordance with this Section to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness will materially assist the Fair Hearing Committee in making its report and recommendation under PART III Section 1 below.

The parties shall be permitted to submit memoranda concerning any issue of law or fact prior to or during the hearing, as stated in Section 5, below.

## **PART II: FAIR HEARING COMMITTEE PROCEDURE**

### **SECTION 1 PERSONAL PRESENCE**

The personal presence of the Practitioner in question is required throughout the hearing, unless such personal presence is excused for any specified time by the Fair Hearing Committee. The presence of the Practitioner's counsel or other representative does not constitute the personal presence of the Practitioner. A Practitioner who fails without good cause to be present throughout the hearing, unless excused, or who fails to proceed at the hearing in accordance with this Fair Hearing Plan, shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Section 4 under Part I of this Plan.

### **SECTION 2 PRESIDING OFFICER**

The Fair Hearing Committee Chair shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. He or she shall determine the order of procedure during the hearing and make all rulings on matters of law, procedure, and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. The Chair of the Fair Hearing Committee shall be entitled to vote.

### **SECTION 3 REPRESENTATION**

The Practitioner may be accompanied and/or represented at the hearing by a Practitioner Member of the Medical Staff or by a member of his or her local professional society. The MEC, or Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent it. Representation of

the Board, MEC, the affected Practitioner, the Fair Hearing Committee, and the Professional Affairs Committee by an attorney at law is permitted and governed by PART VI Section 1 of this Plan.

#### **SECTION 4 RIGHTS OF PARTIES**

During the hearing, each party shall have the following rights, subject to the rulings of the presiding officer on matters of law, procedure and the admissibility of evidence, and provided that such rights shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

- a. call and examine witnesses;
- b. introduce exhibits;
- c. cross-examine any witness on any matter relevant to the issues;
- d. impeach any witness; and
- e. rebut any evidence.

Even if the Practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

#### **SECTION 5 PROCEDURE AND EVIDENCE**

The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. The Fair Hearing Committee may require such memoranda to be filed at a time specified by the Fair Hearing Committee. The Fair Hearing Committee may ask questions of witnesses, call additional witnesses or request documentary evidence if it deems it appropriate. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him or her and entitled to notarize documents in the state where the hearing is held.

#### **SECTION 6 OFFICIAL NOTICE**

In reaching its decision, the Fair Hearing Committee may take official notice, either before or after submission of the matter of decision, of any generally accepted technical or scientific matter relating to the issues under consideration, and/or any facts that may be judicially noticed by the courts of the state where the hearing is held. Participants in the hearing shall be informed of the matters to be noticed, and those matters must be noted in the hearing record. Either party shall have the opportunity to request that a matter be officially noticed and to refute any officially noticed matter by written or oral presentation of authority in a manner to be determined by the Fair Hearing Committee. The Fair Hearing Committee is also entitled to consider all other information that can be considered under the Medical Staff Bylaws in connection with credentials matters.

#### **SECTION 7 BURDEN OF PRODUCTION**

The body whose adverse action or recommendation occasioned the hearing shall have the burden of coming forward with evidence in support thereof. The Practitioner then has the burden of coming forward with evidence that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

## **SECTION 8 HEARING RECORD**

A record of the hearing shall be kept. The Fair Hearing Committee shall determine the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. Both the Practitioner and the Fair Hearing Committee have the right to representation by an attorney (or, with respect to the Practitioner, another person of the Practitioner's choice) at the hearing, and to have a record made of the proceedings, copies of which may be obtained by the Practitioner upon request and payment of any reasonable charges associated with the preparation thereof. Representation of either party by an attorney at law is permitted and governed by PART 6, Section 1 of this Plan.

## **SECTION 9 POSTPONEMENT**

Requests for postponement or continuances of a hearing may be granted by the presiding officer of the Fair Hearing Committee only upon a timely showing of good cause.

## **SECTION 10 PRESENCE OF FAIR HEARING COMMITTEE MEMBERS AND VOTE**

A majority of the Fair Hearing Committee must be present throughout the hearing and deliberations. If a Fair Hearing Committee member is absent from a major part of the hearing or deliberations, the presiding officer, in his or her discretion, may rule that such member not participate further in the hearing or deliberations or in the decision of the Fair Hearing Committee.

## **SECTION 11 RECESSES AND ADJOURNMENT**

The Fair Hearing Committee may recess and reconvene the hearing without written notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The Fair Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

## **PART III: FAIR HEARING COMMITTEE REPORT AND FURTHER ACTION**

### **SECTION 1 FAIR HEARING COMMITTEE REPORT**

Within fourteen (14) days after adjournment of the hearing, the Fair Hearing Committee shall make a written report of its findings and recommendations, with such reference to the hearing record and other documentation and items considered as it deems appropriate. The Fair Hearing Committee shall forward the report along with the record and other documentation to the body whose adverse action or recommendation occasioned the hearing and the Practitioner at the same time.

### **SECTION 2 ACTION ON FAIR HEARING COMMITTEE REPORT**

Within fourteen (14) days after receiving the Fair Hearing Committee report, the body whose adverse recommendations or action occasioned the hearing shall consider said report and shall determine its result, which may be to affirm, modify or reverse its recommendation or action. It shall transmit the result, together with the hearing record, the Fair Hearing Committee report and all other documentation considered, to the Chief Medical Officer and to the Practitioner at the same time.

### **SECTION 3 NOTICE AND EFFECT OF RESULT**

#### **EFFECT OF FAVORABLE RESULT**

- a. Adopted by the Board: If the Board's result under Section 2 of this Part above is favorable to the Practitioner, it shall become effective immediately as the final decision in the matter; and the Practitioner shall be so informed in writing.
- b. Adopted by the MEC: If the MEC's result is favorable to the Practitioner, the Chief Medical Officer shall forward it as soon as practicable, together with all supporting documentation including the report of the Fair Hearing Committee, to the Board which may adopt or reject the result in whole or in part, or refer the matter back to the MEC for further consideration.

Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Board shall take action.

Favorable action by the Board shall become effective as the decision of the Board and the matter shall proceed as provided in Section 3. (a) above. If the Board action is adverse, the written notice shall be sent return receipt requested, and shall inform the Practitioner of his right to request an appellate review by the Professional Affairs Committee. As soon as practicable, the Chief Medical Officer shall send the Practitioner written notice return receipt requested informing him or her of each action taken under this Section.

#### **EFFECT OF ADVERSE RESULT**

For purposes of this Fair Hearing Plan, the term "adverse result" shall mean any action or recommendation by the Board or MEC listed in PART I, Section 1(a)-(n), above.

- a. of the Board: If the result of the Board under Section PART III, Section 2 continues to be adverse to the Practitioner, the written notice shall inform him or her of his or her right to an appellate review, upon proper and timely request, as provided in PART V of this Plan.
- b. of the MEC: If the result of the MEC under PART III, Section 2 continues to be adverse to the Practitioner, the Chief Medical Officer shall forward it as soon as practicable, together with all supporting documentation including the report of the Fair Hearing Committee, to the Board .

The Board shall consider such adverse recommendation as soon as practicable thereafter. The Board is not bound by an adverse recommendation of the MEC, but may take any action it deems warranted by the circumstances, including taking action which accords in all respects with the MEC's adverse recommendation, or is more or less severe, but in any event shall then become effective immediately as the final decision of the Board. If the Board action remains adverse, the written notice, which shall be sent return receipt requested, shall inform the Practitioner of his right to request an appellate review by the Professional Affairs Committee. As soon as practicable, the Chief Medical Officer shall send the Practitioner written notice, return receipt requested, informing him or her of each action taken under this Section.

**PART IV: INITIATION AND PREREQUISITES OF APPELLATE REVIEW BY THE PROFESSIONAL AFFAIRS COMMITTEE**

**SECTION 1 REQUESTS FOR APPELLATE REVIEW**

A Practitioner shall have fourteen (14) days after receiving written notice under PART III, Section 3 to file a written request for an appellate review. The request must be delivered to the Chief Medical Officer by written notice, return receipt requested. If the Practitioner will be represented by an attorney at an appellate review appearance that may be granted under PART V, Section 5, his or her request for appellate review must so state and must advise the Chief Medical Officer at least one week prior to the appellate review appearance.

**SECTION 2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW**

A Practitioner who fails to request an appellate review within the time and in the manner specified shall have waived any right to a review. The waiver has the same force and effect as provided in PART I, Section 4.

**SECTION 3 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW**

The Chief Medical Officer shall deliver a timely and proper request for appellate review to the Chair of the Board. As soon as practicable, the Chair of the Board shall schedule an appellate review to commence not less than thirty (30) days nor more than sixty (60) days after the Chief Medical Officer received the request; provided, however, that an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than thirty (30) days after the Chief Medical Officer received the request.

At least fourteen (14) days prior to the appellate review, the Chief Medical Officer shall send the Practitioner written notice of the time, place and date of the review, as well as a copy of the Fair Hearing Committee report and record and all other material, favorable or unfavorable, if not previously forwarded, that was considered in taking the adverse recommendation or action. The time may be extended by the Chair of the Board or the Professional Affairs Committee for good cause.

**PART V: APPELLATE REVIEW PROCEDURE BEFORE THE PROFESSIONAL AFFAIRS COMMITTEE AND FINAL ACTION**

**SECTION 1 NATURE OF PROCEEDINGS**

The proceedings by the Professional Affairs Committee are a review based upon the prior hearing record(s), the Fair Hearing Committee's report(s), all subsequent results and actions, the written statements, if any, provided below and any other material that may be presented and accepted under Section 5 of this PART.

The Practitioner has the burden of coming forward and proving with evidence that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious. The body whose adverse action or recommendation occasioned the hearing shall then have the burden of coming forward with evidence in support thereof. The Practitioner has the burden of proving that the body whose adverse action or recommendation occasioned the hearing lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

**SECTION 2 WRITTEN STATEMENTS**

The Practitioner may submit a written statement detailing the findings or fact, conclusions and procedural matters with which he or she disagrees and his or her reasons. This written statement may cover any matters raised at any step in the hearing(s) process. The statement shall be submitted to the Professional Affairs Committee (and to the group whose adverse recommendation or action occasioned the appellate review) through the Chief Medical Officer at least seven (7) days prior to the scheduled date of the review, except if the time limit is waived by the Professional Affairs Committee’s presiding officer. Copies of all documents which have been forwarded to the Professional Affairs Committee will also be sent to the Practitioner.

**SECTION 3 PROFESSIONAL AFFAIRS COMMITTEE**

The Professional Affairs Committee shall serve as the appellate review body under this Plan (and may issue a report to the Board per its request as provided in PART I, Section 4.d of this Plan). The Professional Affairs Committee shall consist of six (6) individuals, appointed as needed by the Chair of the Board

Three (3) such members of the Professional Affairs Committee shall be independent members of the Board, as defined in Article I, Section 2(g) of The Westerly Hospital Amended and Restated Bylaws. The other three (3) members of the Professional Affairs Committee shall be Members of the Medical Staff (including physicians employed by the Hospital and its affiliates), or other Practitioners not in competition with the affected Practitioner or practicing in the same specialty area as the Practitioner.

However, if a Medical Staff Member of the Professional Affairs Committee (or other Practitioner, including a physician employed by the Hospital or its affiliates) is required to recuse himself or herself because of prior involvement in the Practitioner’s matter, because he or she is in competition with the affected Practitioner, or because he or she practices in the same specialty area as the Practitioner, the Chair of the Board shall appoint another individual to replace the recused person(s) in accordance with Article VI, Section 15 of The Westerly Hospital Amended and Restated Bylaws.

The Chair of the Board shall appoint the Chair of the Professional Affairs Committee.

**SECTION 4 PRESIDING OFFICER**

The Chair of the Professional Affairs Committee is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

**SECTION 5 ORAL STATEMENTS**

The Professional Affairs Committee, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put by any member of the Professional Affairs Committee.

**SECTION 6 CONSIDERATION OF NEW OR ADDITIONAL MATTERS**

New or additional matters or evidence not raised or presented during the original hearing(s) or in the Fair Hearing Committee report and not otherwise reflected in the record may not be introduced at the appellate review unless the information was not available or reasonably discoverable in time for presentation to or consideration by the Fair Hearing Committee, as determined by the Professional Affairs Committee.



**SECTION 7 PRESENCE OF MEMBERS AND VOTE**

A majority of the Professional Affairs Committee members must be present throughout the review and deliberations. If a member is absent from a major part of the proceedings, the Chair of the Professional Affairs Committee may rule that the member shall not be permitted to participate further in the deliberations or in the decision of the Professional Affairs Committee.

**SECTION 8 RECESS AND ADJOURNMENTS**

The Professional Affairs Committee may recess and reconvene the proceedings without written notice for the convenience of the participants. At the conclusion of the oral statements, if allowed, the appellate review shall be adjourned. The Professional Affairs Committee shall then, at the time convenient to itself, conduct its deliberations outside the presence of the parties.

**SECTION 9 ACTION TAKEN**

Within thirty (30) days after adjournment pursuant to Section 8 above, the Professional Affairs Committee shall prepare its report and findings. The Chief Medical Officer shall send notice of each action taken under this section to the Practitioner by written notice and to the Medical Staff President for transmittal to the appropriate authorities.

The Professional Affairs Committee shall review the hearing record(s), the Fair Hearing Committee’s report(s), all subsequent and prior results and actions, the written statements, if any, provided to the Fair Hearing Committee and any material which was accepted at the hearing before it, to determine whether there is a substantial factual basis for the decisions previously made, and whether those decisions are or are not otherwise arbitrary, unreasonable or capricious, and issue its report and findings.

**SECTION 10 BOARD ACTION FOLLOWING RECIEPT OF PROFESSIONAL AFFAIRS COMMITTEE REPORT AND FINDINGS**

The Professional Affairs Committee’s report and recommendation shall be forwarded to the Board for its decision, which decision shall then be effective as the final decision in the matter.

The Chief Medical Officer shall notify the Practitioner of the Board’s final decision under this Section.

**PART VI: GENERAL PROVISIONS**

**SECTION 1 ATTORNEYS**

**AT HEARINGS**

If the Practitioner desires to be represented by an attorney at any hearing or appellate review, his or her request for the fair hearing or appellate review must declare his or her desire to be so represented. The Practitioner involved has the right to representation by any attorney or other person of the Practitioner’s choice and to have a record made of the proceedings, copies of which may be obtained by the Practitioner upon request and payment of reasonable charges associated with the preparation thereof.

**EQUAL REPRESENTATION AND PREPARATION ASSISTANCE**

Regardless of whether the Practitioner is represented by an attorney at any hearing or appellate review, the MEC, the Board, the Fair Hearing Committee, the Professional Affairs Committee and any other party involved in the Practitioner’s matter shall be allowed the right to legal counsel and representation, including but not limited to the right to legal counsel in connection with preparation for a hearing or any appellate review.

**SECTION 2      NUMBER OF HEARINGS AND REVIEWS; DECISION BY MAJORITY**

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner is entitled as a matter of right to request more than one hearing before the Fair Hearing Committee and one appellate review before the Professional Affairs Committee with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right. All decisions by the Fair Hearing Committee and the Professional Affairs Committee shall be by majority.

**SECTION 3      RELEASE**

By requesting a hearing or appellate review under this plan, a Practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability.

**SECTION 4      PROVISION OF NOTICE AND PERFORMANCE OF OTHER RESPONSIBILITIES BY DESIGNEES**

If any party obliged to provide notice or perform other responsibilities under this Fair Hearing Plan is absent from the Westerly area or otherwise unavailable when obliged to do so, then his or her designee shall perform such duties during that unavailability.

**GENERAL RULES AND REGULATIONS  
FOR THE MEDICAL STAFF**

**PART ONE: ADMISSION OF PATIENTS**

**Rule #1**

**TYPES OF PATIENTS**

The Hospital accepts all patients for care and treatment except for the following categories where facility and personnel are limited:

- a. Psychiatric patients requiring locked ward treatment
- b. Head trauma requiring urgent or immediate surgery
- c. Extensive third or second degree burns
- d. Chemical dependency rehabilitation

Patients are admitted without regard to race, creed, color, sex, sexual preference, disability, age, national origin, or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the Chief Medical Officer after consultation with the applicable Department Chief.

**Rule #2**

**SELF-TREATMENT OF IMMEDIATE FAMILY MEMBERS**

In accordance with the AMA Code of Ethics, Medical Staff Members cannot provide care to an immediate family member at the Hospital. In emergency/life threatening settings, or where no other qualified physician is available, the treating physician is permitted to treat their family member until another qualified physician becomes available.

**Rule #3**

**ADMITTING PRIVILEGES**

**GENERALLY**

Only appropriately privileged Members of the Medical Staff may admit patients to the Hospital and subject to the conditions provided below and to all other official admitting policies of the Hospital as may be in effect from time to time.

**LIMITATIONS FOR DENTISTS AND PODIATRISTS**

Dentist and podiatrist Members with appropriate privileges may admit patients to the Hospital, but a physician member of the Active Medical Staff must perform a basic medical appraisal (including history and physical examination) for each dental and podiatric patient. This must be performed prior to any operation or procedure and, if possible prior to admission or thereafter consistent with the requirements of these Rules related to history and physical examination. The appraisal must include an evaluation of the overall medical risk and effect of any planned operation or procedure on the patient's health.

**Rule #4**

**ADMISSION INFORMATION**

A patient will not be admitted to the Hospital until the Practitioner requesting admission provides a provisional diagnosis. Other required documentation or information specific to the type of admission involved should be in

the record within a reasonable time following admission not to exceed 24 hours. This information must be based on an in-person evaluation of the patient within twelve (12) hours prior to admission. The admitting Practitioner must communicate the following information concerning a patient to be admitted: any source of communicable or significant infection; behavioral characteristics that would disturb or endanger others; need for protecting the patient from self-harm.

**Rule #5**

**TIMELY VISITATION AFTER PATIENT ADMITTED**

The responsible attending Practitioner or his/her designee must see the patient within twenty four (24) hours from the time of admission, or sooner if the patient's condition requires it.

**PART TWO: ASSIGNMENT AND ATTENDANCE OF PATIENTS**

**Rule #6**

**ATTENDANCE OF PATIENTS**

Each patient admitted to the Hospital shall be attended to by the Practitioner of his/her own choice, provided said Practitioner has the appropriate clinical privileges. A patient who is to be admitted and who has no personal practitioner may request any Practitioner who is a member of the Active Medical Staff and who has appropriate clinical privileges. When no such request is made, or when the requested Practitioner chooses not to undertake the care of the patient, a member of the Active Medical Staff with the requisite privileges (hereinafter called the original admitting physician) will be assigned to the patient according to the on-call schedule of the applicable department.

That patient's follow-up care will be the responsibility of the original admitting physician for thirty (30) days from the date of Hospital discharge. If the patient returns to the Hospital within those thirty (30) days and requires Hospital admission, the original admitting Practitioner is responsible for the care of the patient which falls within that Practitioner's specialty.

Patient follow-up care can also be transitioned to another Practitioner or facility that has agreed to provide follow-up care for the patient.

If the original admitting Practitioner does not wish to provide follow-up care for the patient, he/she should note this in the medical record and notify the patient, both verbally and in writing, of the recommendations that have been made regarding follow-up.

If arrangements have been made for another Practitioner or facility to provide follow-up care for the patient, it is the responsibility of the original ordering Practitioner to make the receiving physician/facility providing such follow-up aware of the cause for admission, significant findings and occurrences during the hospitalization, and the treatment rendered.

If the patient's follow-up care has transitioned to another practitioner who is not a member of the Active Medical Staff, then if the patient returns to the Hospital and requires admission within the thirty (30) day period, the original admitting Practitioner will be responsible for that Hospital care which falls within his/her specialty during that admission.

If the patient signs out of the Hospital against medical advice, the Practitioner shall no longer be responsible for the care of the patient.

**Rule #7**

**PARTICIPATION IN THE ON-CALL ROSTER**

Unless specifically exempted by the applicable department for good cause shown, each member of the Active Medical Staff agrees that, when he/she is the designated Practitioner on call, he/she will accept responsibility during the time specified by the published schedule for providing care to any patient in any unit of the Hospital referred to the service for which he/she is providing on-call coverage.

**Rule #8**

**POLICY FOR PHYSICIAN COVERAGE**

It is the responsibility of attending and consulting Medical Staff Members to provide continuous coverage for inpatients either personally or by formally designating an alternative physician. The alternate physician must be a member of the Medical Staff of equal or greater clinical privileges.

It is the responsibility of all physician Members of the Medical Staff to provide coverage for out of hospital and emergency clinical needs including Hospital admissions. The covering physician must be a member of the Medical Staff with equal or greater clinical privileges.

**Rule #9**

**POLICY FOR ADDRESSING NON-AVAILABILITY**

**First Instance Of Non-Availability**

- a. Evaluation by Department Chair

**Second Incident**

- a. Reviewed by Department Chief and President of the Medical Staff
- b. Documentation maintained in medical staff file

**Third Incident**

- a. Reviewed by Department Chief and President of the Medical Staff
- b. Suspension of admitting and procedure privileges for fourteen (14) days
- c. Notification of Medical Executive Committee
- d. Permanent record in medical staff file

**Additional Episode**

As above, plus thirty (30) day suspension

**Recurrence**

Medical Staff member is subject to automatic termination of membership and privileges

**Rule #10**

**PEER REVIEW (Professional Practice Evaluation) PROCESS**

Purpose and Responsibility:

The sole responsibility for peer review rests with the Professional Practice Evaluation Committee (PPEC). Its function is outlined in ARTICLE XII, Section 10

## **PART THREE: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE**

### **Rule #11**

#### **GENERALLY**

A Medical Staff Member shall be responsible for the medical care and treatment of the patients in the Hospital assigned to him/her, for the prompt completeness and accuracy of those portions of the medical record for which he/she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient. Primary responsibility for these matters belongs to the admitting Practitioner except when transfer of responsibility is affected pursuant to Rule #12.

### **Rule #12**

#### **TRANSFER OF RESPONSIBILITY**

When primary responsibility for a patient's care is transferred from the admitting or current attending Practitioner to another Member of the Medical Staff, a note covering the transfer of responsibility and acceptance of the same must be entered on the order sheet and progress notes.

### **Rule #13**

#### **ALTERNATE COVERAGE**

Each Practitioner must assure timely, adequate professional care for his/her hospitalized patients by being available or designating a qualified alternative Practitioner with whom prior arrangements have been made and who has the requisite clinical privileges to care for the patient.

When out of town or unavailable, Members of the Medical Staff must indicate the name of the Practitioner who will be assuming responsibility for the care of the patient during his/her absence. In the absence of such designation, the Chief Medical Officer, the President of the Medical Staff or the applicable Department Chief has the authority to contact any Member of the Medical Staff with the appropriate clinical privileges.

Failure of an attending Practitioner to meet these coverage requirements may result in loss of staff membership or such other disciplinary action, as the MEC deems appropriate.

### **Rule #14**

#### **DENTISTS, PODIATRISTS AND HEALTH PROFESSIONAL AFFILIATES**

Dentists, podiatrists and health professional affiliates may treat patients under the conditions provided in ARTICLE VII, Sections 4 and 5 in Rule #3.

Each dentist, podiatrist and health professional affiliate is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he/she provides to the patient.

More specifically, dentists and podiatrists are responsible for the following:

- a. A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;
- b. A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis;
- c. A complete operative report, describing the findings, technique, specimens removed and postoperative diagnosis;
- d. Progress notes as are pertinent to the dental/podiatric condition;

- e. Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge; and,
- f. Clinical resume of final summary note.

#### **Rule #15**

##### **POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE**

If a nurse or other caregiver involved in the care of a patient has any reason to doubt or question the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, and whose concerns have not been resolved after discussion with the attending physician, such individual shall bring the matter to the attention of the individual's supervisor who, in turn, may refer the matter to the relevant Department Chief. Where circumstances are such as to justify such action, the Department Chief may request a consultation.

#### **Rule #16**

##### **RESPONSIBILITY FOR CONSULTATIONS**

The good conduct of medical practice includes the proper and timely use of consultation. The attending Practitioner primarily responsible for the patient is also responsible for calling for consultations from other qualified Practitioners who are Members of the Medical Staff when the provision of care is outside the scope of their delineated privileges or expertise and as indicated or required pursuant to the guidelines in Rule #17 below. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable Department Chief, the President of the Medical Staff, or the Chief Medical Officer. If the responsible attending Practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the President of the Medical Staff or the applicable Department Chief for final decision and direction.

#### **Rule #17**

##### **GUIDELINES FOR CALLING CONSULTATIONS**

Unless the attending Practitioner's expertise is in the area of the patient's problem, consultation with a qualified physician is required in the following cases:

- a. When required by state law.
- b. When the rules of any clinical unit, including any intensive or special care units, of the staff require it.
- c. When requested by the patient or family.

#### **Rule #18**

##### **QUALIFICATIONS OF CONSULTANT**

Any qualified and appropriately privileged Practitioner may be called as a consultant regardless of his/her staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board. A consultant must have demonstrated the skill and judgment requisite for evaluation and treatment of the condition or problem presented and have been granted appropriate clinical privileges.

**Rule #19**

**DOCUMENTATION OF CONSULTATIONS**

- a. Consultation Request: When requesting consultation, the attending Practitioner must make an appropriate entry into the electronic medical record indicating the reason for the request.
- b. Consultant's Report: The consultant must make and sign a report of his/her findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record.

**PART FOUR: TRANSFER OF PATIENTS**

**Rule #20**

**TRANSFER TO ANOTHER FACILITY / GENERAL REQUIREMENTS**

A patient shall be transferred to another medical care facility only upon the order of the attending Practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient.

**Rule #21**

**TRANSFER TO ANOTHER FACILITY / DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT**

A transfer demanded by an emergency or critically ill patient or his/her family or significant other is not permitted until a physician has explained to the patient or his/her family or significant other the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

**PART FIVE: DISCHARGE OF PATIENTS**

**Rule #22**

**REQUIRED ORDER**

A patient may be discharged only on the order of the responsible attending or his/her covering Practitioner. The attending Practitioner is responsible for documenting the principal diagnosis, secondary diagnosis, co-morbidities, complications, principal procedures, and additional procedures in of the patient's medical record within seventy two (72) hours of discharge.

**Rule #23**

**LEAVING AGAINST MEDICAL ADVICE**

If a patient desires to leave the Hospital against the advice of the attending Practitioner or without proper discharge, the attending Practitioner shall be notified and the patient will be requested to sign the appropriate release form. If a patient leaves the Hospital against the advice of the attending Practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.



**Rule #24**

**DISCHARGE OF MINOR PATIENT**

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents or legal guardian, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record

**PART SIX: ORDERS**

**Rule #25**

**GENERAL REQUIREMENTS**

All orders for treatment or diagnostic tests must be entered into the electronic medical record accordingly and signed by the responsible Medical Staff Member. Orders for diagnostic tests, which necessitate the administration of test substances or medications, will be considered to include the order for this administration.

**Rule #26**

**STANDING ORDERS**

All standing orders shall be listed on an instruction and order sheet that must be included in the patient's medical record and signed and dated by the attending Practitioner. Standing orders shall be considered as a specific order by the attending Practitioner for that patient and shall be followed in the absence of other specific orders by the attending Practitioner, insofar as the proper treatment of the patient will allow.

**Rule #27**

**VERBAL ORDERS / BY WHOM AND CIRCUMSTANCE**

A registered nurse or pharmacist as authorized in the policies and procedure manual of the Hospital may take telephone or verbal orders. Verbal and telephone orders may be accepted and executed by the following within their scope of practice as defined by their State of RI licensure:

- Registered nursing staff
- Licensed practical nurses
- Registered pharmacists
- Respiratory care practitioners
- Registered physical therapists
- Registered occupational therapists
- Licensed speech-language pathologists
- Licensed audiologists
- Radiologic technologists
- Registered Sonographers
- Registered Nuclear Medicine Technologists
- Registered Dieticians

Verbal orders shall be authenticated as required by State and Federal law and regulations.

## **Rule #28**

### **DOCUMENTATION OF VERBAL ORDERS**

All verbal and telephone orders shall be read back and documented in the proper place in the electronic medical record and shall be authenticated by the prescribing Member of the Medical Staff within twenty four (24) hours.

## **Rule #29**

### **ORDERS BY AFFILIATED HEALTH CARE PROFESSIONALS**

An Affiliated Health Care Professional who is a registered nurse practitioner, certified registered nurse anesthetist, or physician assistant may enter orders consistent with the scope of services individually defined for the specific profession, the individual's privileges and applicable state laws. If a health professional affiliate is in FPPE status, all orders must be co-signed by their supervising/collaborating physician until FPPE is concluded. Supervision requirements are as follows:

- New graduates (i.e. received license within one year of initial appointment):  
Direct supervision for all for the initial ninety (90) days following appointment to the Medical Staff. The supervising physician must be physically present, or within an immediate distance on the Hospital campus, and available to respond to the needs of the health professional affiliate; the supervising physician gives specific instructions on all assignments; work is reviewed for completeness and accuracy.
- New appointees (who have prior hospital practice experience greater than one year):  
direct supervision of all for the initial thirty (30) days following appointment. The supervising physician must be physically present, or within an immediate distance on the Hospital campus, and available to respond to the needs of the Affiliated Health Care Professional; the supervising physician gives specific instructions on all assignments; work is reviewed for completeness and accuracy.

Following the initial period of required direct supervision as described above, intermittent supervision is required as follows;

The supervising physician makes assignments by defining objectives, priorities and deadlines, and assists the Affiliated Health Care Professional with unusual situations that do not have clear objectives. The Affiliated Health Care Professional plans and carries out successive steps and resolves problems and deviations in accordance with instructions, policies, and accepted practices. The supervising physician reviews the work for technical adequacy and conformance with standard clinical practice policy.

## **Rule #30**

### **AUTOMATIC CANCELLATION OF ORDERS**

All previous orders are automatically discontinued when the patient goes to surgery or is transferred to another service or another level of service. The attending Practitioner must re-enter new orders, re-institute all or some of the orders, or refer to another Practitioner for a decision on whether or not to re-institute all or particular orders.

**Rule #31**

**BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS**

Blood transfusions and intravenous infusions must be initiated by the attending physician or by a registered nurse who has the requisite training and has been credentialed to do so. The order must specifically state the rate of infusion.

**Rule #32**

**PATIENTS OWN DRUGS AND SELF-ADMINISTRATION**

Drugs brought into the Hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending Practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner and in accordance with established Hospital policy.

**Rule #33**

**DO NOT RESUSCITATE**

In the case of a patient with an irreversible, terminal condition, a "Do Not Resuscitate" order is acceptable. The attending physician must enter the order on the order sheet and progress notes. Adequate documentation, including any consents/authorizations, and any notices required shall be accomplished in accordance with the hospital's "Do Not Resuscitate" policy.

**Rule #34**

**FORMULARY DRUGS**

The Hospital formulary lists drugs available for ordering from stock. Each Member of the Medical Staff assents to the use of the formulary as approved by the Pharmacy Committee. All drugs and medications administered to patients shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

**Rule #35**

**INVESTIGATIONAL DRUGS**

Use of investigational drugs must be in full accordance with all Regulations of the Food and Drug Administration and must be approved by the Institutional Review Committee. Investigational drugs shall be used only under the direct supervision of the principal investigator. The principal investigator shall be responsible for receiving all necessary consents and completing all necessary forms and shall prepare and clarify directions for the administration of investigational drugs as to untoward symptoms, special precautions in administration, proper labeling of the container, proper storage of drug, methods of recording doses when indicated, and method of collection and recording specimens of urine and/or other specimens.

**PART SEVEN: INPATIENT MEDICAL RECORDS**

**Rule #36**

**REQUIRED CONTENT**

The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

- a. Identification data
- b. Personal and family medical histories
- c. Description and history of present complaint and/or illness
- d. Physical examination report
- e. Diagnostic and therapeutic orders
- f. Evidence of appropriate informed consent
- g. Treatment provided
- h. Progress notes and other clinical observations, including results of therapy
- i. Special reports, when applicable (such as clinical laboratory, radiology, radiotherapy, EEG, EKG, consultation, pre and post anesthesia, operative and other diagnostic and therapeutic procedures, etc.)
- j. Pathological findings
- k. Final diagnosis without the use of symbols or abbreviations
- l. Condition on discharge, including instructions, to the patient or significant other on post-hospital care.
- m. Autopsy report, when available.

**Rule #37**

**HISTORY AND PHYSICAL EXAMINATION**

Maintain a consistent process for the completion of Medical Records as outlined in the Rules and Regulations. Specifically, A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days before or twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within twenty four (24) hours of admission. When the medical history and physical examination are completed within thirty (30) days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition shall be required to be completed. This updated examination must be completed and documented in the patient's medical record within twenty four (24) hours after admission and prior to any surgical procedure or procedure requiring anesthesia services.

**Rule #38**

**USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION**

External to Hospital: If a qualified member of the Medical Staff has obtained a complete history or has performed a complete physical examination prior to admission, based on the allowable timeframe (thirty (30) days), as required by the Centers for Medicare and Medicaid Services prior to the patient's admission to the hospital, a durable, legible copy of the report may be used in the patient's Hospital medical record, provided that an interval admission note is recorded that includes all additions to the history and any changes in the physical findings subsequent to the original report.

**Rule #39**

**PREOPERATIVE DOCUMENTATION / HISTORY AND PHYSICAL EXAMINATION**

A relevant history and physical examination is required for each patient having surgery. Except in an emergency as documented in the electronic medical record by the Practitioner who will perform the surgery or any other

procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart. If the history and physical examination have been dictated but are not on the chart at the time of surgery, a note must be entered before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. If not recorded, the anesthesiologist shall not allow the surgery to proceed.

In cases of emergency, the responsible Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed.

#### **Rule #40**

##### **LABORATORY TESTS**

Appropriate advance lab tests must be performed within thirty (30) days prior to admission for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia.

#### **Rule #41**

##### **PREOPERATIVE ANESTHESIA EVALUATION**

The anesthesiologist must conduct and document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent anesthetic problems, ASA patient status classification, and orders for preoperative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

#### **Rule #42**

##### **PROGRESS NOTES**

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending Practitioner.

Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending Practitioner must be entered at least daily on all patients. Progress notes entered by a physician-directed health professional affiliate must be countersigned within twenty four (24) hours and supplemented every twenty four (24) hours by the responsible supervising physician.

#### **Rule #43**

##### **OPERATIVE AND SPECIAL PROCEDURE REPORTS**

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary Practitioner who performed the procedure and any assistants.

If the report is dictated and not available in the record immediately after the procedure, the Practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. Either a

brief operative report or the full operative report; must be entered or dictated immediately following the procedure, available in the medical record as soon after the procedure as possible, and promptly authenticated by the primary performing practitioner. If the full operative report is not dictated immediately following the procedure, it must be completed within one (1) day of surgery.

#### **Rule #44**

##### **TISSUE EXAMINATION AND REPORTS**

All tissue, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room at the time of removal, and sent to the Pathology Department.

A pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made part of the medical record.

#### **Rule #45**

##### **POST-OPERATIVE ANESTHESIA EVALUATION**

A post-operative anesthesia evaluation must be performed and documented on inpatients within forty eight (48) hours after a procedure requiring anesthesia services.

#### **Rule #46**

##### **DISCHARGE SUMMARY**

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure and any additional procedures must be recorded in full, and must be dated and signed by the attending Practitioner within seventy two (72) hours of the patient's discharge. The following definitions are applicable to the terms used herein:

- a. Principal diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- b. Secondary diagnosis (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
- c. Co-morbidities (if applicable): A condition that coexisted at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day.
- d. Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.
- e. Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
- f. Additional Procedures (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.
- g. In General: A discharge summary must be recorded for all patients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the

procedures performed and treatment rendered and the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission.

**Rule #47**

**DISCHARGE INSTRUCTIONS TO PATIENTS**

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow up care. If no instructions were required, a record entry must be made to that effect.

**Rule #48**

**AUTHENTICATION**

All clinical entries in the patient's record must be accurately dated and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials or electronic signature.

**Rule #49**

**USE OF SYMBOLS AND ABBREVIATIONS**

Symbols and abbreviations may be used only when the Medical Executive Committee has approved them. An official record of approved symbols and abbreviations is available at each nursing station and in the medical records department.

**Rule #50**

**FILING**

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the department Chief shall complete the necessary documentation of the medical record.

**Rule #51**

**TIMELY COMPLETION OF MEDICAL RECORDS**

All medical records must be completed within twenty-one (21) days of review and notation of deficiencies by the Clinical Information Department. Deficiencies will be addressed in accordance with the Medical Records Completion and Fine Assessment Policy.

**Rule #52**

**ACCESS TO MEDICAL RECORDS**

Access to the electronic medical record shall be governed in accordance with appropriate policies and procedures of Yale New Haven Health.

**Rule #53**

**PATIENT ACCESS TO RECORDS**

A patient may, upon written request to the Hospital, have access to all information contained in his/her medical records according to Hospital policy, unless access is specifically restricted or prohibited by law.

**Rule #54**

**ACCESS TO RECORDS ON READMISSION**

In the case of readmission of a patient, all previous records shall be available for use by the current attending Practitioner.

**Rule #55**

**ACCESS TO RECORDS TO FORMER MEDICAL STAFF MEMBERS**

Subject to the discretion of the Chief Medical Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the past.

**Rule #56**

**PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES**

Written consent of the patient or legally qualified representative is required for release of medical information to persons not otherwise authorized by law to receive this information.

**PART EIGHT: CONSENTS**

**Rule #57**

**GENERAL CONSENT**

Each patient's medical record must contain evidence of the patient's or his/her legal representative's general consent for treatment during hospitalization.

**Rule #58**

**INFORMED CONSENT**

The performing and/or attending Practitioner, where applicable, is responsible for obtaining the patient's or his/her legal representative's informed consent for the procedures and treatments listed below:

- a. Anesthesia;
- b. Surgical and other invasive procedures;
- c. Use of experimental drugs;
- d. Organ donation;
- e. Chemotherapy;



- f. Autopsy;
- g. Photography;
- h. Blood Transfusions.

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

- a. Patient identity
- b. Date and time when patient was informed
- c. Nature of the procedure or treatment proposed to be rendered.
- d. Name(s) of the individual(s) who will perform the procedure or administer the treatment.
- e. Authorization for any required anesthesia.
- f. Indication that the risks and complications of the procedure or treatment and of the alternatives available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment.
- g. Authorization for removal of any tissue or body parts as indicated.
- h. Name of the Practitioner who informs the patient and obtains the consent.

An informed consent must be signed by the patient, or on the patient's behalf by the patient's authorized representative, and witnessed by a legally competent third party.

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Rule #58 without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record.

## **PART NINE: SPECIAL SERVICES UNITS AND PROGRAMS**

### **Rule #59**

#### **DESIGNATION**

Special services units and programs include, but are not limited to, the following:

- a. ICU-CCU Unit
- b. Emergency Room
- c. Operating Room
- d. Post Anesthesia Care Unit
- e. Ambulatory Care Unit

Appropriate officers, committees, and representatives of the Medical Staff and its Departments will develop, in coordination with applicable Hospital departments, specific policies for the special services units and programs, covering, when applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/ program, consultation requirements, admission/discharge/transfer protocols, direction of the unit/ program, authority of the physician director of the unit/program/special record keeping

requirements, scheduling of patients, etc. The policies of the various units and programs are subject to approval of the MEC and the Chief Medical Officer.

## **PART TEN: HOSPITAL DEATHS AND AUTOPSIES**

### **Rule #60**

#### **HOSPITAL DEATHS**

In the event of a patient death in the Hospital, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable period of time.

Reporting deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local law.

The attending physician must sign the death certificate unless the death is a Medical Examiner's case in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician issues the death certificate.

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician Member of the Medical Staff. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law.

### **Rule #61**

#### **AUTOPSIES**

Members of the Medical Staff are encouraged to secure autopsies whenever possible in all cases of unusual deaths and those of medical-legal and educational interest – deaths in which patient sustained or apparently suffered an injury while hospitalized; deaths known or suspected to have resulted from environmental or occupational hazards; deaths of patients that have participated in clinical trials approved by the IRB.

Proper consent for an autopsy shall be in accordance with applicable state law. All autopsies shall be performed by the hospital pathologist, or by his/her qualified designee.

The provisional anatomic diagnosis must be recorded on the medical record within seventy two (72) hours; and the complete protocol shall be made a part of the medical record within sixty (60) business days. These rules do not apply to cases which according to law must be referred to the Medical Examiner's Office.